Performance

Report

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| Name: | Gawler Grande Views |
| Commission ID: | 6894 |
| Address: | 3 Duffield Street, GAWLER EAST, South Australia, 5118 |
| Activity type: | Site Audit |
| Activity date: | 11 October 2023 to 16 October 2023 |
| Performance report date: | 8 December 2023 |
| Service included in this assessment: | Provider: 2933 Martindale ACF Pty Ltd  Service: 4308 Gawler Grande Views |

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 Stewart Brumm, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 10 November 2023.
* Notice to Agree issued 21 April 2023.
* Information provided to the Commission in relation to the Notice to Agree issued 21 April 2023.
* Performance report dated 16 June 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

* Ensure each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Including establish effective monitoring process to monitor staff conduct.
* Ensure care and services are culturally safe. Including establish effective monitoring process to monitor staff conduct and monitoring consumer preferences for culturally safe care delivery.
* Ensure each consumer is supported to exercise choice and independence. Including monitoring consumer choices are being followed by staff.
* Ensure each consumer’s privacy is respected and personal information is kept confidential. Including establish processes to identify and monitoring consumers preferences for who is involved in and informed of consumer care status.
* Ensure 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. Including the completion of outstanding assessments and care planning.
* Ensure 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. Including a review of all consumers end of life wishes is completed and care documentation is updated.
* Ensure assessment and planning 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 includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. Including a review of processes to ensure there is ongoing partnership occurring.
* Ensure the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. Including providing consumers and or representatives access to copies of the care plans.
* Ensure 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. Including completing all outstanding care reviews, including lifestyle information.
* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care. Including but not limited to effective medication management, diabetic management, pain management, and falls management.
* Ensure effective management of high impact or high prevalence risks associated with the care of each consumer. Including but not limited to ensuring effective management of restrictive practice.
* Ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. Including a review of all consumers end of life wishes is completed and care documentation is updated. Ensure effective monitoring processes are established to ensure delivery of end of life care is occurring and meets consumer care needs.
* Ensure deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. Ensure process to monitor change and deterioration in a consumer is reviewed and effective.
* Ensure 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.
* Ensure 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. Ensure consumers are supported to attend activities of choice.
* Ensure services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. Ensure emotional needs assessments are completed for all consumers.
* Ensure information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.
* Ensure the service environment enables consumers to move freely, both indoors and outdoors. Including completing the relocation of the memory support unit.
* Ensure 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. Including monitoring the workforce to ensure safe and quality care is being delivered.
* Ensure workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Establish processes to effectivity monitor staff conduct.
* Ensure the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Establish processes to monitor staff knowledge, including post training and education sessions.
* Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Ensure training provided has been effective to enhance staff knowledge and behaviours to deliver the outcomes required by the Aged Care Quality Standards.
* Ensure regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Ensure reflective practice tools are consistently used.
* Ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Review monitoring processes to ensure care and services are provided in accordance with the Aged Care Quality Standards.
* Ensure effective organisation wide governance systems relating to information management, continuous improvement, workforce governance and regulatory compliance. Review processes to monitor governance systems are effective.
* Ensure effective risk management systems and practices. Review processes to monitor risk management to ensure it is effective.
* Ensure the clinical governance framework is effective, including monitoring of actions to improve clinical care and governance.

# Other relevant matters:

The Approved Provider indicated that are seeking to sell the service.

# 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. | Not Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Not 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. | Not Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Not Compliant |

Findings

Requirement 1 (3)(a)

The Assessment Team provided information that consumers and representatives said staff do not treat consumers with dignity and respect and gave recent examples of when this had occurred. Staff described what treating consumers with dignity and respect means, however, confirmed not all staff were displaying this when interacting with or discussing consumers and their representatives. Interactions with, and observations of staff showed behaviours and language being used that did not effectively convey dignity and respect towards consumers and their representatives.

For named consumers this included the disrespectful manner in which staff were interacting with them or their representatives. As well as observations made by the Assessment Team of potential disrespectful and inappropriate language used when communicating with a consumer and observations of staff behaviour that did not show respect to consumers.

The Approved Provider provided a response that included clarifying information as well as a summary from the information provided to the Commission as part of the Notice of Agree, a summary of the quality of life survey, critical incident reports, and policies.

The Approved Provider has provided education to staff on culturally safe care, has polices relating to the organisation code of conduct and cultural competence. I note the response rate to the quality-of-life survey was completed by less than half of the consumers or their representatives.

Management at the Service have spoken with named consumers and/or their representatives following the Site Audit, one consumer has relocated within the service to address concerns raised about other wandering consumers, one representative has not been able to be contacted and another has expressed improvement in the attitude of staff. The Approved Provider acknowledge the behaviour of staff outlined in the Assessment Team report is not acceptable, however noted that these events were historical, and have not reoccurred under the new management team. Staff have been informed of the concerns raised and expectations for respectful behaviour has been discussed with staff.

In response to the observations made by the Assessment Team, the staff involved in the overheard conversation were stood down pending investigation into their conduct. Both staff have performance improvement plans established, have reflected on their practice and will be allocated to work in the memory support unit.

I have considered the information provided by the Assessment Team and the Approved Provider and I note that whilst education has been provided to staff and some consumers have been surveyed for their feedback, the processes to monitor staff conduct and consumer satisfaction have not been effective in consistently identifying issues of concern to consumers or their representatives. I note the Approved Provider is responsive in addressing issues that are raised.

I am not satisfied that the actions taken have demonstrated sustainable monitoring processes to ensure ongoing compliance with this requirement. I am persuaded by the feedback provided by consumers and representatives and the observations made by the Assessment Team during the Site Audit.

I find this requirement is non-compliant.

Requirement 1 (3)(b)

This requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that care and services provided were not culturally safe, specifically in relation to consumers’ staff gender preferences for care. While staff feedback and care documentation described consumers’ preferences, this was not demonstrated in the care and services provided. As well as there were no documented actions undertaken in response to the finding of non-compliance.

For named consumers this included consumers and representatives stating they continued to receive personal care from staff members who do not align with their identified gender preferences. Staff were not consistently aware of consumers cultural identity.

The Approved Provider provided a response that included clarifying information as well as a summary from the Notice of Agree, a summary of the quality-of-life survey, continuous improvement plans, previous commission reports, clinical records extracts, assessments, and a door card.

I note the Approved Provided developed action plans to address the noncompliance from the April 2023 Site Audit, with long term improvements captured on the continuous improvement plan. The Approved Provider believes they have made significant progress in relation to improvements, however they identified that many improvements continue in the development stage and will be progressed by the current management.

In regard to a named consumer and preference for female only staff, I note the actions previously taken by the Approved Provider in June 2022 to address this matter and that care documentation was updated to reflect gender preferences. However, this alone does not demonstrate ongoing compliance and note the consumer provided feedback to the Assessment Team during this Site Audit that the issue is ongoing, and they continue to have male staff attending to their care on occasions.

Management has spoken with the other consumers and/or their representatives to understand their concerns and preferences and care documentation has been updated to reflect the gender preference for care.

Management have spoken with another consumer in relation to their heritage and cultural background and assessments and care documentation has been updated to reflect the consumers wishes. The Approved Provider has indicated that the consumers’ cultural background was known by the Service and the consumer has indicated they prefer not to be treated any different to the other consumers.

I have considered the information provided by the Assessment Team and the Approved Provider and I find whilst actions have been taken previous or post the site audit to ensure care documentation reflects consumer choice of gender preference, I am not satisfied that processes to identify consumer preferences and or monitor staff compliance with preferences is consistently effective. I am persuaded by the consumer feedback provided to the Assessment Team at the time of the Site Audit.

I find this requirement is non-compliant.

Requirement 1 (3)(c)

The Assessment Team provided information that while consumers were supported to maintain relationships of choice, not all were supported to make decisions about their care, the way services were delivered or who is to be involved in their care.

For named consumers this included decisions about being transferred to hospital and decisions about who is informed about consumers care and services.

The Approved Provider provided a response that included clarifying information as well as clinical records extracts.

In regard to a representative’s preference for their consumer to not be transferred to hospital, I note that the representative was contacted in relation to the staff’s concerns about the consumer’s deterioration and that an Ambulance had been called to attend the Service and assess the consumer. I accept the Approved Provider’s assertion that contacting the Ambulance is a valid intervention if staff were unable to contact the medical officer. I note the consumer was not transferred to hospital as per the representative’s wishes and the consumer was provided treatment at the Service. I note that management have discussed ongoing care for the consumer with the representative with a range of preferences and management strategies discussed.

I accept the Approved Provider’s response that an Agency Staff member had contacted a representative against the wishes of the consumer, and care documentation has been updated to highlight the consumer’s preferences.

I also accept that another consumer’s representative was provided information about the consumer against the wishes of the consumer, that an apology was provided by management and care documentation has been updated to reflect the consumer’s preference.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that at the time of the Site Audit, one consumer was not transferred to hospital, in-line with the representative’s preference. However, processes to consistently identify and monitor consumers’ preferences for who is involved in and informed of consumers’ care status, was not consistently effective, and preferences were not followed. The sustainability of improvement actions has yet to be assessed as effective.

I find this requirement is non-compliant.

Requirement 1 (3)(d)

This requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that staff were able to demonstrate knowledge of consumers who take risks, in relation to leaving the Service and smoking, and how they are were supported. However, staff were not able to demonstrate how a consumer is supported to take risks to enable them to live the best life they can in relation to food and diet choices.

For a named consumer this included not being supported to eat foods that were outside of the recommended diet.

The Approved Provider’s response included clarifying information as well as extracts of clinical records, a dignity of risk form, and handover materials.

The Approved Provider met with the named consumer during the Site Audit and completed a dignity of risk form, and explained the risks associated with the food to the consumer. Clinical records and handover sheets were updated, and the kitchen was informed of the consumer’s preferences. The consumer has been provided a diet of choice since the Site Audit.

I have considered the information provided by the Assessment Team and the Approved Provider and I note the Assessment Team identified staff knowledge of consumers who take risks, and I note the actions taken by the Approved Provider at the time of the Site Audit in relation to food choices for a consumer. I note the deficit identified impacted one consumer, was rectified at the time of the Site Audit and actions have been sustained to meet the consumer’s preference. I also note improvements made to the electronic care system to ensure alerts are transferred to handover sheets.

On balance of the information provided, I am satisfied that this is not a systemic issue, that staff generally demonstrated knowledge of managing consumers who take risks, and actions taken have been sustainable.

I find this requirement compliant.

Requirement 1 (3)(e)

This requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team identified that information provided to each consumer was current, accurate and timely. Consumers said information was communicated clearly, was easy to understand and enabled them to exercise choice.

I find this requirement compliant.

Requirement 1 (3)(f)

The Assessment Team provided information that there were systems and processes to ensure consumers’ privacy was respected and their personal information was kept confidential. However, care documentation and observations showed processes were not being followed to ensure this occurred. The Assessment Team observed computers in the nurse's station were unlocked and logged into the electronic care documentation system when there were no staff in the station. The door to the nurse's station was observed to not be able to be fully closed and locked, allowing access to other consumers and visitors.

For named consumers, care information was shared with representatives against the wishes of consumers.

The Approved Provider’s response included clarifying information as well as memorandum, email correspondence and extracts of clinical records.

A memorandum to staff on ensuring privacy of information, as well as a change to the ~~e~~lectronic systems to time out after 5 minutes of inactivity. These actions occurred at the time of the Site Audit.

In regard to the named consumers, the Approved Provider acknowledge the information was shared, as outlined under Requirement (3)(c), consumer preferences have been reaffirmed and care documentation has been updated.

I have considered the information provided by the Assessment Team and the Approved Provider and I accept the measures implemented to time out inactivity to electronic systems will reduce the likelihood of consumer information being accessed in nurse’s stations.

However, processes to consistently identify and monitor~~ing~~ consumers’ preferences for who is involved in and informed of consumer care status, were not consistently effective, and preferences were not followed. This resulted in confidential information being shared. The sustainability of improvement actions has yet to be assessed as effective.

I find this requirement non-compliant.

Not all Requirements in this Standard are compliant, as such the overall Standard rating is Not 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. | Not 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. | Not 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. | Not 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. | Not 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. | Not Compliant |

Findings

Requirement 2 (3)(a)

This Requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that assessment and planning, including consideration of risks to the consumer’s health and well-being, did not inform the delivery of safe and effective care and services.

For named consumers this included assessments and planning had not been consistently completed, including individualised behaviour support plans, management of a consumer with a high falls risk and consumers who were subject to restrictive practices.

Consumers with chemical restraint were not identified with authorisations for administration evidence or discussions undertaken with consumers/representative in the risk involved in the administration of the medications. Two consumers had their beds floor line restricting them for getting out of bed, however no assessment was completed to discuss the risks involved in the implementation of a mechanical restraint for the consumers.

The Approved Provider provided a response that included clarifying information as well as a summary from the information provided to the Commission as part of the Notice of Agree, a care evaluation schedule, clinical records extracts, information sheets, medical reports, external support agency correspondence.

The Approved Provider’s response included clarifying information as well as a summary from the final report of Notice of Agree, a care evaluation schedule, extracts of clinical records, information sheets, medical reports, and external support agency correspondence.

The Approved Provider recruited two Clinical nurses from a nursing agency to conduct an audit of care plans and care evaluations post the Site Audit in April 2023, this included referrals to external support agencies and updating behaviour support plans. The Approved Provider acknowledge the gaps in lifestyle assessments due to vacancies in staffing and had allocated this work to the clinical team.

In relation to named consumers and behaviour support plans, one consumer was being actively monitored and having ongoing involvement and assessment by an external support agency, including staff from the agency being on site during the Site Audit to support staff in the management of the consumer’s behaviours. They note the behaviour support plan has been reviewed and amended following input from the external support agency and a visiting Geriatrician. For the second consumer, the Approved Provider noted that the behavioursupport plan was only recently developed and therefore has had limited time to be reviewed for effectiveness.

In relation to named consumers and restrictive practice, following the Site Audit the Approved Provider has conducted assessments, and commenced paperwork to support the use of restraint, however I note the medical officer is yet to complete restraint authorisations and the Service is waiting for a representative to respond to attempts to discuss the use of restraint for a consumer. In regard to the use of seclusion, the Approved Provider does not agree that seclusion is being used, but rather it is a known and documented behaviour management strategy for the consumer to have ‘quiet time/or time out’ as part of effective behaviour management, they have indicated that this occurs not only in the consumers room, but in other areas of the Service.

In relation to the named consumer who is a high falls risk, the Approved Provider acknowledges the gaps in assessment and planning and has subsequently conducted further assessments and updated care documentation.

I have considered the information provided by the Assessment Team and the Approved Provider and I find the Approved Provider has not demonstrated 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. Consumers care needs are not consistently being effectively assessed. Whilst I acknowledge the Approved Providers actions taken since the Site Audit, the existing processes had not identified consumers subject to restrictive practice, nor effectively assessed a consumer with a high falls risk. I note the ongoing work to develop personalised behaviour support plans being undertaken by the Approved Provider, including working with external support agencies to identify and manage consumers challenging behaviours. However, I note the effectiveness of this work is yet to be evaluated.

I find this requirement non-compliant.

Requirement 2 (3)(b)

This Requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that assessments and care plans did not include personalised goals, needs and preferences, including lifestyle assessments to guide staff in the provision of safe and effective care. Representatives said changes were not made to assessments to reflect consumers’ current needs, although staff had been informed on several occasions.

For named consumers this included where female or male care staff are preferred for activities of daily living and palliative assessments did not capture consumers’ wishes and goals when entering the end-of-life phase. As well as incomplete lifestyle assessments.

The Approved Provider provided a response included clarifying information as well as extracts of clinical records, assessments, and previous Commission reports.

In relation to identifying and meeting consumers preferences for gender of staff providing care, as outlined under Standard one, I note the actions previously taken by the Approved Provider in June 2022 to address this matter and that care documentation was updated to reflect gender preferences. However, this alone does not demonstrate ongoing compliance and note the consumer provided feedback to the Assessment Team during this Site Audit that the issue is ongoing, and they continue to have male staff attending to their care on occasions. I note the care documentation has been updated for the other named consumer to capture staff gender preferences.

In relation to lifestyle assessments, the Approved Provider has acknowledged that these assessments were not consistently completed due to staffing vacancies. I note that since the Site Audit assessments for named consumers have commenced and were being completed. I note that one consumer was being actively assessed, including involvement of an external support agency and care documentation continues to be updated.

For another consumer, I do not consider that ongoing management of their medications addresses the Assessment Team information of staff not being aware of the consumers needs and preferences. I note that improvements have been made to the recording of pain as a potential trigger to behaviours, with staff educated on the pain assessment tool and pain being record on behaviour monitoring as needed.

In relation to end of life assessments and palliative care, the Approved Provider has acknowledged deficits relating to this, and has contacted named consumers and or their representative to gain further information on end of life and palliative care preferences. Care documentation continues to be updated.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that the Approved Provider has not established effective processes to ensure compliance with this requirement. I am persuaded by the deficits identified in Assessment Team information and note that deficits identified by the Approved Provider have impacted compliance, including staffing vacancies in the lifestyle team.

I find this requirement is non-compliant.

Requirement 2 (3)(c)

This Requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that representatives said some communication has improved, and confirmed they were informed of all changes to consumers' needs, including incidents or decline in consumers’ health and care needs. However, assessment and planning were found not to be based on ongoing partnership with the consumer and others the consumer wishes to involve other organisations.

For named consumers this included gender preferences for care delivery and consultation on restrictive practice.

The Approved Provider provided a response that included clarifying information as well as well a clinical records extracts, and care evaluations.

In relation to 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, I note the Approved Provider has implemented a care evaluation process, that includes contacting the consumer and nominated representatives and capturing any feedback provided. I note the positive feedback provided by representatives in relation to improved communication relating to changes in consumers. However, I am not persuaded that this process is consistently effectively. The care evaluation process had not identified where consumer preferences were not being effectively managed in relation to consumer preference for gender of staff to provide care, nor had it identified the deficits in ensuring informed consent had been obtained for the use of restrictive practice. It has also not identified deficits in end of life planning highlighted in the Assessment Team overall report.

In relation to including other organisations, and individuals and providers of other care and services, that were involved in the care of the consumer. The Approved Provider has demonstrated that this is occurring, with external support services, allied health professionals and medical officers being involved in the ongoing assessment and planning of care.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that whilst the Approved Provider is able to demonstrate compliance with aspects of this requirement, ongoing deficits remain in the ongoing partnership with consumers or representatives in relation to assessment and planning.

I find this requirement is non-compliant.

Requirement 2 (3)(d)

This Requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that consumers and representatives said they were not consulted throughout the assessment process. Five of 8 representatives and 4 of 13 consumers stated they were not contacted in relation to assessments and care plans, nor have they viewed them. Staff were unable to demonstrate how they ensure consumers and representatives were involved in the assessment process, to ensure information captured within assessments and care plans meet the consumer’s goals, needs and preferences. Management confirmed the assessment and reassessment process is under review and were working on undertaking a complete review of all consumers’ assessments in consultation with consumers and representatives.

Clinical staff informed the Assessment Team that they have undertaken a complete review of 12 of the 61 consumers’ assessments and working on communicating with consumers and representatives to ensure all information captured meets consumers’ needs.

The Approved Provider provided a response that included clarifying information as well as a care plan evaluation schedule, care evaluations.

The Approved Provider acknowledge consumers and/or representatives have not been able to access copies of their care plan, and they have plans to enable this to occur.

In relation to communicating with consumers and representatives about the outcomes of assessment and planning, I note the Approved Provider has commenced a process to conduct care plan reviews and involve the consumer and representatives in this process, this is an ongoing process, and the effectiveness is yet to be evaluated. In relation to the incomplete review of consumers assessments and care plans, the deficit identified in completing these is related to completing lifestyle assessments and has been impacted by staff vacancies in the lifestyle team.

I have considered the information provided by the Assessment Team and the Approved Provider, and I am persuaded by the acknowledgement from the Approved Provider that consumers and representatives have not been able to access copies of their care plans to review, and that the outcomes of assessments and planning is not being consistently communicated due to delays in completing assessments and planning.

I find this requirement non-compliant.

Requirement 2 (3)(e)

This requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that care and services had not been reviewed regularly for effectiveness, when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer. Clinical staff informed the Assessment Team that they have undertaken a complete review of 12 of the 61 consumers’ assessments. All assessments and care plans that were reviewed by the Assessment Team did not include the consumer's needs, goals and preferences.

For named consumers care plans were not consistently reviewed, this related to falls management, behaviour support plans, diabetic management, medication management and restrictive practice.

The Approved Provider’s response included clarifying information as well as clinical records extracts, care plan review schedule and care evaluations.

The Approved Provider has acknowledged that care reviews had not been completed, due to incomplete assessment and planning information, for lifestyle assessments that have been impacted by staff vacancies. A care plan review schedule has been developed and is in operation, 57 out of 60 care plans have been reviewed through this process. However, it is noted that this is an ongoing process and that assessments are continuing to be undertaken to inform care planning, and care plans updated with consumers goals and preferences.

In relation to a named consumer, the Approved Provider acknowledge that consumers had not been effectively reviewed post falls and has updated the high-risk management meeting to capture sufficient information to inform care reviews.

I note that in relation to behaviour support plans, these are ongoing in both development and review, with the Approved Provider engaged with external support agencies in the management of these consumers’ behaviour. The plans will reflect the effective strategies post the ongoing assessment.

In relation to named consumers and diabetic management, medication management and restrictive practice, I note that since the Site Audit care documentation has been updated to reflect the changes in care provision.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that whilst the Approved Provider has established a care review scheduled and is conducting care reviews on a 6-month basis, the process to conduct reviews post incidents or for changes in a consumer’s condition is not consistently occurring. I also note the care reviews being undertaken with ongoing issues of incomplete care assessment and planning.

I find this requirement is non-compliant.

Not all Requirements in this Standard are compliant, as such the overall Standard rating is Not 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | Not 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. | Not 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. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirement 3 (3)(a)

This requirement was previously found non-compliant following Site Audit in April 2023.

The Approved Provider has completed the following improvements:

* The Medication manual was reviewed and implemented to assist and guide staff in the safe management of medication administration.
* The process to monitor consumers on fluid restrictions was reviewed and additional monitoring processes implemented.

The Assessment Team provided information that each consumer was found not to be receiving safe and effective personal and clinical care. While staff confirmed they have completed training and could describe some processes relating to these areas of care, documentation did not show these processes were being undertaken consistently. Policies and procedures were available to guide staff in the management of diabetes, medication administration and pain. However, staff were not following these when providing related care to consumers.

For named consumers this included deficits in management of diabetes, administration of time sensitive medications and monitoring and management of pain.

The Approved Provider provided a response that included clarifying information as well as a summary from the information provided to the Commission as part of the Notice of Agree, clinical records extracts, and handover sheets.

In relation to a named consumer and diabetic management, records reviewed identified deficits in the management of blood glucose level monitoring and medication was not provided in line with medical officer directives, the Approved Provider has acknowledged the findings of the Assessment Team. Care documentation has been updated to reflect required monitoring, information has been added to the handover sheets and the white board in the nurses’ station.

For another named consumer and diabetic management, the Approved Provider has updated care documentation to ensure consistent information is available to guide staff practice.

In relation to the named consumers and medication management, including the delayed administration of time sensitive medications. The Approved Provider has not disputed the findings of the Assessment Team and has commenced corrective actions to improve the management of time sensitive medications, including counselling staff on expect performance around medication management. Time sensitive medications have been added to handover sheets, have been packed separate to other medications, and care alerts added to the electronic care management system.

In relation to the named consumer and pain management, the Approved Provider has implemented changed processes to monitor and record consumers’ pain. Pain monitoring is now occurring both as part of behaviour monitoring and pain monitoring. This is to identify if pain is a trigger for increased behaviour. Care staff have also been provided additional training on identifying pain and recording this information and not relying on old drop-down menus in the electronic care management system.

The Approved Provider also accepted the feedback recorded for another named consumer relating to pain, however identified the timing of the matter occurred prior to the current management team.

I accept the Approved Provider could not response to comments that were not attributed to a named consumer or representative for some information in the Assessment Team report.

I have considered the information provided by the Assessment Team and the Approved Provider and I am persuaded in my finding by the information presented by the Assessment Team and the acknowledgement from the Approved Provider in relation to the deficits in the processes to provide care to consumers, and I note the improvement actions that have commenced. However, the sustainability and effectiveness of these improvements is yet to be evaluated.

I find this requirement non-compliant.

Requirement 3 (3)(b)

This requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that effective management of high impact or high prevalence risks associated with the care of consumers was not demonstrated. Regular high-risk meetings are undertaken, however, do not demonstrate discussions of strategies are undertaken or additional strategies discussed and implemented to assist in managing high impact or high prevalence risks.

For named consumers this included specifically in relation to management of falls, behaviours, and restrictive practices.

The Approved Provider provided a response that included clarifying information as well as a clinical records extracts, information sheets, medical reports, and external support agency correspondence.

In relation to the named consumers and management high falls risks, the Approved Provider has acknowledged the deficits in falls management. Consumers have been assessed and care documentation amended as required. A falls management process has also now been established. Clinical staff have been counselled over the need to conduct follow up actions on 24-hour progress note reviews.

In relation to named consumer and the management of behaviours. The Approved Provider acknowledge the information in the Assessment Team report. A review of behaviour charting has been completed and amendments have been made to care documentation. The Approved Provider does not consider that the service is using seclusion as restrictive practice and noted that the consumer enjoys time alone and it is a noted and working behaviour management strategy to remove the consumer from sources of agitation and spend some quiet time alone in an area of the service, including the bedroom or other quiet areas.

In relation to the named consumer and management of behaviours the Approved Provider provided information the consumer was being actively monitored and having ongoing involvement and assessment by an external support agency, including staff from the agency being on site during the Site Audit to support staff in the management of the consumers behaviours. I note the behaviours support plan has been reviewed and amended following input from the external support agency and a visiting geriatrician. The consumers medications have also been adjusted over this time in response to the increased drowsiness. However, there is no response from the Approved Provider in relation to the consumer representative being consulted about the increase in sedative medications.

In relation to the identification and management of restrictive practice, the Approved Provider refutes the Assessment Team Report indicating staff did not have knowledge of what constituted restrictive practice, however they acknowledged they were not able to demonstrate that consent had been obtained for the use of restrictive practice. This has been added to the plan for continuous improvement and will be completed by January 2024.

I have considered the information provided by the Assessment Team and the Approved Provider. In determining my findings, I am persuaded by the information presented in the Assessment Team report and the Approved Providers acknowledgement of this information. I note improvement actions have commenced and are being managed via the plan for continuous improvement.

I find this requirement is non-compliant.

Requirement 3 (3)(c)

This requirement was previously found non-compliant following the Site Audit in April 2023.

The Assessment Team provided information that needs, goals and preferences of consumers nearing the end-of-life had not been recognised and addressed. End-of-life care plans had not always been commenced when a consumer reached end-of-life, nor were they personalised to consumers’ wishes. When an end-of-life care pathway is commenced, progress notes are not consistently completed to monitor the consumer to ensure comfort is maximised. Progress notes demonstrated inconsistent observations and medication management for one consumer on a syringe pump during end-of-life care.

The Approved Provider provided a response that included clarifying information as well as clinical records extracts, complaints and outcomes information, a palliative care procedure and training materials.

The Approved Provider has acknowledged that for the named consumers, palliative care was not provided in a satisfactory manner and the outcomes for the consumers was not ideal.

In response the information provided in the Assessment Team report, the Approved Provider has implemented a palliative care procedure, has introduced additional palliative care resources, including palliative care boxes and purchased an additional syringe pump. Staff have been provided learning packages as part of ongoing training requirements.

I have considered the information provided by the Assessment Team and the Approved Provider. In determining my findings, I am persuaded by the information presented in the Assessment Team Report and the Approved Providers acknowledgement of this information. I note improvement actions have commenced and are being managed via the plan for continuous improvement. I also note the Approved Provider accepted that the outcomes for the named consumers was not ideal.

I find this requirement is non-compliant.

Requirement 3 (3)(d)

This requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that deterioration or change of a consumer’s condition has not been effectively managed. Appropriate monitoring and actions were not completed when consumers’ health declined, or when vital signs were not within an acceptable range for the consumers.

For named consumers this related to diabetic management, vital signs monitoring and general deterioration.

The Approved Provider provided a response that included clarifying information as well as clinical records extracts.

The Approved Provider acknowledged the Assessment Team findings in relation to monitoring of consumer change and deterioration and how this is managed.

In relation to a named consumer and changes in diabetic management, the Approved Provider acknowledged that changes had not been effectively managed. Staff have been counselled regarding actions to take for changes in diabetic management.

In relation to a named consumer observed to be unwell during the Site Audit, the Approved Provider has indicated and provided clinical records extracts to demonstrate the consumer was being monitored for a time prior to the Site Audit, and subsequent monitor has occurred.

The Approved Provider has provided education to the clinical staff on following up actions in the 24-hour progress note review process, and this includes the monitoring of vital signs.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that processes to identify and monitor consumers for changes in condition and deterioration have not been consistently effective. I note the Approved Providers acknowledgement of the information presented in the Assessment Team report. I am persuaded in my finding by the information presented by the Assessment Team and the Approved Providers acknowledge of this information.

I find this requirement is non-compliant.

Requirement 3 (3)(e)

The Assessment Team provided information that information about consumers’ condition, needs and preference is not consistently documented and communicated within the organisation, and with others where responsibility for care is shared. Consumers and representatives interviewed stated there has been a large turnover of staff and a lack of staff to provide adequate care consistently to consumers. Care plans and assessments are not current to assist and guide staff in the provision of consumers’ care and services.

The Approved Provider provided a response that included clarifying information as well as correspondence with representatives.

The Approved Provider acknowledged the information in the Assessment Team report regarding documenting and sharing information effectively. The Approved Provider also acknowledges the high turnover of staff in the previous 6 months. However, they note that the service now has a stable leadership team. They also provided correspondence indicating improved communication with a consumer’s representative. Improvements to care planning and sharing of information continues.

I have considered the information provided by the Assessment Team and the Approved Provider. In determining my findings, I am persuaded by the information presented in the Assessment Team Report and the Approved Providers acknowledgement of this information. I note improvement actions have commenced, however are yet to be evaluated for sustainability and effectiveness.

I find this requirement is non-compliant.

Requirement 3 (3)(f)

This requirement was previously found non-compliant following the Site Audit in April 2023.

The Approved Provider has completed the following improvements:

* A review was completed with allied health services contracts to ensure consumers had access to appropriate external specialists including speech pathologists, Dietitians and physiotherapists.
* The Assessment Team provided information that timely and appropriate referrals to individuals and other organisations were found to be initiated, when needed. Consumers and representatives said other organisations were involved in consumers’ care. Staff described a range of organisations/providers and referral processes in delivery of care and services, and policies in relation to referral support were available to guide staff. Documentation showed external services were actively involved in consumers’ care.

I have considered the information provided by the Assessment Team and I find this Requirement compliant.

Requirement 3 (3)(g)

The Assessment Team provided information that minimisation of infection related risks were managed through implementation of standard precautions, and practices promote the appropriate management of antibiotic prescriptions and reduce antibiotic use. Consumers and representatives said they were well informed of what was occurring throughout outbreaks. Staff confirmed they had received training, including in relation to infection control, COVID-19 and hand washing, and demonstrated knowledge in relation to reducing the use of antibiotics.

I have considered the information provided by the Assessment Team and I find this requirement compliant.

Not all requirements in this Standard are compliant, as such the overall Standard rating is Not 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. | Not Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Not 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

Requirement 4 (3)(a)

This Requirement was found non-compliant following the Site Audit in April 2023.

The Assessment Team provided information that each consumer was not receiving safe and effective services and supports for daily living that meet their needs, goals and preferences, or which optimise their independence, health, well-being and quality of life. While consumers and representatives said laundry services have improved, consumers who are not mobile said they are not provided with supports to be able to participate in lifestyle activities to promote their well-being. Staff confirmed consumers who are not able to attend activities independently are not assisted to attend, and lifestyle staff said they do not have capacity to be able to assist all consumers to attend and promote engagement for those consumers.

The memory support unit has a dedicated activities calendar; however, it includes activities outside of the unit. Staff confirmed only 2 consumers attend most activities outside of the unit and for consumers who are not able to attend these, minimal planned activities occur.

Whilst the Assessment Team observed activities to occur in some areas of the service, where consumers were not able to attend these activities, they were observed sat in lounge areas or dining rooms with no stimulation or engagement being provided by staff.

Observations of meal services identified consumers were not provided with the assistance they required to be able to complete their meals.

The Approved Provider provided a response that included clarifying information as well as a summary from the information provided to the Commission as part of the Notice of Agree, activity records, clinical records extracts, memorandum, and newsletters.

For a named consumer, the Approved Provider indicated that the consumers’ medication was being adjusted by the medical officer during the time of the Site Audit and acknowledge this caused them to be drowsy. However, they note that since the medication has been stabilised, the consumer is more alert and more engaged, including being taking for walks (in a wheelchair) around the service. Additionally care alerts have been added to the electronic care system to prompt staff to provide additional emotional support.

For other named consumers, the staff have engaged the consumers to ascertain their preferences for activities. Care alerts have been added to the electronic care system to encourage the consumers out of their rooms and to provide additional emotional support.

For another named consumer, engagement with the representative has occurred and the consumer has been reviewed by a dietitian, staff will continue to support the consumer with diet choices.

In regard to staff advised the Assessment Team they do not have capacity to assist all consumers to activities, the Approved Provider noted this was a past issue and not a regular occurrence. A memorandum has been provided to staff to remind staff about teamwork and assisting lifestyle staff to move consumers around the service.

In regard to activities in the memory support unit, the Approved Provider contends that there are activities provided and all consumers in the unit are welcome to attend activities across the service. Additional staffing resources have been provided to support activities in the unit. The Approved Provider also believes that activities for consumers will improve once the unit is relocated to the ground floor, and consumers will have access to an outdoor courtyard.

In regard to staff engagement for consumers not attending group activities, the Approved Provider accepted this feedback from the Assessment Team and commenced addressing this matter with staff during the Site Audit. This included providing education to staff on the importance of consumer engagement.

In regard to providing assistance to consumers with meals in the dining room and bedrooms, the Approved Provider appreciated the feedback provided by the Assessment Team. Management have spoken to staff about providing assistance and note the consumers may vary in level of assistance required and time taken to complete meals. Staff have also been given education around the importance of consumers quality and enjoyment of meals. The Approved Provider also indicated distant supervision of consumers is provided during meals.

I have considered the information provided by the Assessment Team and the Approved Provider and I note that improvements have been commenced in relation to the provision of activities to all consumers and support for consumer during meals and noting lifestyle staffing vacancies have been filled. However, I also note that improvements are still pending, including relocating the memory support unit to the ground floor. I am not persuaded that the effectiveness of these improvements, completed and planned and have been demonstrated as effective.

I find this Requirement is non-compliant.

Requirement 4 (3)(b)

This Requirement was found non-compliant following the Site Audit in April 2023.

The Assessment Team provided information that services and supports for daily living did not promote each consumer’s emotional, spiritual and psychological well-being. Consumers and representatives said consumers’ emotional, spiritual and psychological well-being is not supported by staff. Lifestyle staff said they are not able to provide emotional and psychological supports to individual consumers and the volunteer program is not able to assist them. Assessments relating to emotional support, religious and spiritual are not completed, nor strategies developed to guide staff in how to support each consumer.

The Approved Provider provided a response that included clarifying information as well as photographs, and activity records.

For a named consumer, the Approved Provider indicated that the consumers’ medication was being adjusted by the medical officer during the time of the Site Audit and acknowledge this caused them to be drowsy and affected their level of engagement. However, they note that since the medication has been stabilised, the consumer is more alert and more engaged, including being taking for walks (in a wheelchair) around the service. Additionally care alerts have been added to the electronic care system to prompt staff to provide additional emotional support.

In regard to named consumers and incomplete assessments, the Approved Provider acknowledge this gap in assessment and planning and noted that vacancies within the lifestyle team had impacted the completion of assessments. Since the Site Audit, assessments have commended and consumer and representatives have been engaged, I note this process is ongoing and not completed for all consumers. Care alerts have also been added to certain consumers electronic care records to prompt staff to engage and provide additional emotional support.

In regard to lifestyle staff not having time to provide emotional support, the Approved Provider has indicated that additional lifestyle staff, including a coordinator have been recruited, and believe that ongoing needs of consumers will be met.

I have considered the information provided by the Assessment Team and the Approved Provider and I acknowledge the increase in staffing levels, and actions taken to remind staff about the provision of emotional support. However, I am persuaded in my findings that lifestyle assessments, including emotional support needs are still be completed for all consumers and the effectiveness of the additional staff, including the coordinator commencing in late November 2023 has yet to be evaluated as effective in meeting consumer’s needs.

I find this Requirement is non-compliant.

Requirement 4 (3)(c)

This Requirement was found non-compliant following the Site Audit in April 2023.

The Assessment Team provided information that consumers said they are supported to participate in the community outside the service, have personal and social relationships and do things of interest to them. Staff were able to identify relationships consumers have and consumers who are involved in the community outside of the service. Consumers were observed to be spending time with family and visitors in the communal areas and talking to each other.

I have considered the information provided by the Assessment Team and I find this requirement is compliant.

Requirement 4 (3)(d)

The Assessment Team provided information that information about consumers’ condition, needs and preferences is not consistently documented and communicated within the organisation, and with others where responsibility for care is shared. Consumers and representatives interviewed stated there has been a large turnover of staff and a lack of staff to provide adequate care consistently to consumers. Care plans and assessments are not current to assist and guide staff in the provision of consumers’ care. Leisure and social assessments, cultural and spiritual assessments and emotional assessments for consumers had not been completed to guide staff in the strategies used to support consumers. Care plans do not reflect consumers need and goals and are not personalised.

For named consumers this included incomplete assessments, care plans not personalised and not including needs and goals, a consumer’s diet information.

The Approved Provider provided a response that included clarifying information as well as clinical records extracts, email correspondence with representatives.

The Approved Provider acknowledged that care planning, including person centred care, individualised care and goal setting is in progress and will continue to be communicated to staff, consumers and partners in care, as part of this ongoing evaluation process. Staff have been encouraged to capture consumer information to the handover sheets to assist staff, and rosters have been adjusted to facilitate handovers between shifts. Following the Site Audit a whiteboard has been installed in the kitchen. On this board the diet, allergies and dislikes of each consumer are visible for kitchen staff.

For named consumers, consultation has occurred to commence and or complete lifestyle assessments, care documentation has been updated to reflect the consumers’ needs and preferences.

I have considered the information provided by the Assessment Team and the Approved Provider and I am persuaded in my findings that the process to conduct assessments and care planning to support information sharing between staff is yet to be completed. As such staff do not have access to all relevant information about consumers condition, needs and preferences.

I find this requirement non-compliant.

Requirement 4 (3)(e)

The Assessment Team provided information that consumers said they are supported by other organisations, support services and providers of other care and services. Consumers confirmed involvement of spiritual services, library services, mental health services and well-being support. Staff were able to explain how they work with other organisations and individuals to provide support to consumers. Management said they have a plan to be able to expand their local community networks to provide increased services to consumers, including with different spiritual care providers.

I have considered the information provided by the Assessment Team and I find this requirement is compliant.

Requirement 4 (3)(f)

The Assessment Team provided information that four consumers and one representative were not satisfied with the meals provided. Care documentation did not always reflect the current dietary needs for the consumers. While staff were knowledgeable about consumers’ needs and preferences, observations of the dining experiences showed consumers were not always provided with the assistance they required. Observations of the dining experience across all levels of the service showed consumers were not provided with a dining experience that supports their quality of life. This included the presentation of the dining rooms and staff assistance during meals. The Approved Provider did, however, have some understanding of this Requirement, particularly in relation to the management of food allergies and intolerances and using forums to improve the menu.

The Approved Provider provided a response that included clarifying information as well as memorandum, electronic care system extracts, meeting records and draft menu.

In regard to the dining experience, the Approved Provider has indicated that this was addressed during the site audit. A memorandum was provided to staff on the expectations for the dining experience. All tables within the service now are set with place mats, condiments and napkins.

In regard to staff providing assistance to consumers, a review of staffing and meal breaks has been conducted to ensure all staff are available to assist consumers during meal times. Staff have been provided education around the importance of supporting consumers quality and enjoyment of meals.

Named consumers and/or their representatives have been consulted in relation to meals and dining, with noted preferences and expectations for care captured.

Management and head cook are working with the dietitian and consumers to make changes and update the current menu. Food focus meetings are being held monthly and a new summer menu has been drafted.

I have considered the information provided by the Assessment Team and the Approved Provider. In determining my findings, I have considered the generic nature of the consumer and representative feedback provided by the Assessment Team in regard to meal satisfaction. I note the food monthly focus meetings and the content of that meetings indicating consumers are satisfied with the meals, that they noticed and improvement in meals, one consumer looks forward to mealtimes now, and that changes have occurred to remove meals the consumers do not like from the menu, I also note feedback on an improving dining experience for consumers. The new summer menu has been developed and all consumers have been provided a copy for review and feedback. I also note under Standard 6, that the Approved Provider is operating a functioning complaints system to manage consumer or representative feedback effectively.

I am persuaded by this information, and the actions already implemented by the Approved Provider.

I find this requirement is compliant.

**Requirement 4 (3)(g)**

The Assessment Team provided information that equipment provided is safe, suitable, clean and well maintained. Consumers and representatives said equipment is clean and well maintained, and if issues arise, they are addressed promptly. Staff confirmed there is adequate equipment available for consumers and knew how to escalate issues to maintenance. Processes have been implemented to ensure reactive and preventative maintenance of equipment continues in a timely manner.

I have considered the information provided by the Assessment Team and I find this requirement is compliant.

Not all Requirements in this Standard are compliant, as such the overall Standard rating is Not 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. | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Requirement 5 (3)(a)

The Assessment Team provided information that consumers and representatives said the service environment was welcoming and comfortable. Consumers were mobilising around the service with ease and familiarity. The environment had sufficient spaces for consumers to conduct activities or sit in a quiet area of the service. Management and staff confirmed consumers were able to personalise their rooms and encouraged them to do so.

I have considered the information provided by the Assessment Team.

I find this requirement is compliant.

Requirement 5 (3)(b)

This requirement was previously found non-compliant following Site Audit in April 2023.

The Assessment Team provided information that the Service did not demonstrate a safe service environment that enables enabled consumers to move freely, both indoors and outdoors. Two consumers said they did not feel safe living at the Service. The Assessment Team noted that the memory support unit is located on level one of the buildings and has no direct access an outdoor area. There are currently 8 consumers who reside within the unit. Staff informed the Assessment Team that consumers who do not mobilise independently, require a lot of supervision or experience changed behaviours were not taken downstairs to the courtyard.

Management informed the Assessment Team they were planning on moving the memory support unit to the ground floor to enable consumers residing in this area to have access to the outdoor courtyard.

The Approved Provider provided a response that included clarifying information as well as correspondence with families, extracts of clinical recordsand a lifestyle calendar.

The Approved Provider is in the process of relocating the memory support unit to the ground floor, this requires refurbishment of rooms, as well as ongoing discussions with both consumers and representatives as well as those being asked to move from the ground floor to accommodate the move. The courtyard area off this area is also planned for refurbishment. The planned refurbishments and relocation of consumers is due for completion 25 December 2023.

In response to the staff feedback about moving consumers around the Service, the Approved Provider has indicated that this is not the policy of the Service. A lifestyle staff member has been allocated to the memory support unit 3 days a week, to not only facilitate increased activities and engagement, but to assist consumers to move around the Service, including going outdoors.

In relation to the 2 named consumers who reported feeling unsafe at the Service, due to other wandering consumers, the Approved Provider was unable to progress investigation into one named consumer, as the details reported do not match the situation for that consumer. The other consumer is currently residing on the ground floor in the area being refurbished. Once the consumer and their representative have selected a new room, and potentially relocated, it is envisaged by the Approved Provider that this will prevent reoccurrence. The wandering consumer that is impacting this consumer has been placed on frequent sighting observations to monitor they are not going into the consumer’s room.

The Approved Provider has also offered locks for consumers’ doors. Any consumer concerned about wandering consumers or for a sense of increased safety have had locks provided for their room doors.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that whilst the Approved Provider is implementing plans to improve the service environment to enable consumers to move freely both indoors and outdoors, I note these improvements have not been completed and have not been evaluated as effective in achieving the desired outcomes. I am persuaded by this in my findings.

I find this requirement is non-compliant.

Requirement 5 (3)(c)

This Requirement was previously found non-compliant following Site Audit in April 2023.

The following actions have been completed as part of the continuous improvement:

* Completed a review of the system and discussed the identified issues with the IT provider.
* A new phone system was installed in May 2023.

The Assessment Team provided information that furniture, fittings and equipment was observed to be safe, clean and well maintained. Consumers and representatives said they were satisfied with the cleaning of equipment, fittings and furniture. There were processes to monitor and track preventative and reactive maintenance for furniture, fittings and equipment and a list of preferred external contractors was available for all staff in maintenance logs.

I have considered the information provided by the Assessment Team.

I find this requirement compliant.

Not all Requirements in this Standard are compliant, as such the overall Standard rating is Not 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6 (3)(a)

The Assessment Team provided information that all consumers and representatives interviewed said they were encouraged and supported to provide feedback and make complaints through a variety of feedback mechanisms. Staff were knowledgeable of feedback processes and confirmed assisting consumers to provide feedback when required. Service documentation confirmed embedded feedback processes included a consolidated feedback report, business processes, surveys, feedback forms and consumer forum minutes.

I have considered this information provided by the Assessment Team and I find this requirement compliant.

**Requirement 6 (3)(b)**

The Assessment Team provided information that consumers and representatives said they were made aware during the admission process and on an ongoing basis about accessing advocates, language services and other methods for raising and resolving complaints. Staff were guided by a complaints management policy which outlines the use of advocacy and interpreter services when required. Written advocacy and language service brochures were available at the reception area, and the service’s Resident and Representative Information handbook, provided to each consumer, included information on advocacy services.

I have considered this information provided by the Assessment Team and I find this requirement compliant.

**Requirement 6 (3)(c)**

This requirement was previously found non-compliant following Site Audit in April 2023.

The Approved Provider has completed the following improvements:

* Feedback information was provided to consumers at a Resident and Representative meeting. Information included a copy of the service's feedback form, contact details for external complaints avenues and general information regarding feedback processes.
* Review of the Feedback and Complaints Management policy to include feedback received via consumer forums as part of the internal complaints process to further identify opportunities for continuous improvement.
* Open disclosure education provided in staff meeting forums, including what is open disclosure and how it applies in practice.
* Monthly review of consumer and representative feedback sourced verbally, in writing or via consumer forums to identify opportunities for improvement.
* Review of the Feedback and Complaints Management policy to include feedback received via consumer forums as part of the internal complaints process to further identify opportunities for continuous improvement.

The Assessment Team provided information that consumers and representatives confirmed the service were prompt to make contact when things went wrong and confirmed the Service apologises or expresses regret at these times. Consumers and representatives said they feel complaints were handled well and addressed in a timely manner. Staff were guided in the complaints management process by a Feedback and Complaints Management policy and open disclosure policy, and staff were knowledgeable of open disclosure principles.

I have considered this information provided by the Assessment Team and I find this requirement compliant.

**Requirement 6 (3)(d)**

This requirement was found non-compliant following a Site Audit in April 2023.

The Approved Provider has completed the following improvements:

* Monthly review of consumer and representative feedback sourced verbally, in writing or via consumer forums to identify opportunities for improvement.
* Review of the Feedback and Complaints Management policy to include feedback received via consumer forums as part of the internal complaints process to further identify opportunities for continuous improvement.

The Assessment Team provided information that consumers and representatives said they provide feedback and complaints to the Service and have noticed changes to care, and services based on the feedback they have provided. Business processes were in place to guide staff in ensuring feedback provided was identified, captured, actioned, and reviewed. Feedback and complaints documentation demonstrated opportunities for improvement identified by management based on complaints data which were reflected on the Services plan for continuous improvement.

I have considered this information provided by the Assessment Team and I find this requirement compliant.

All Requirements in this Standard are complaint, as such the overall Standard is rated 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. | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not 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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

Requirement 7 (3)(a)

The Assessment Team provided information that all consumers and representatives interviewed confirmed there are adequate numbers of staff to provide care and services. Consumers said they have confidence in the abilities of permanent staff across all designations, however, 3 of 13 consumers said they had experienced delays in care and service provision but had not previously discussed this with management. Staff said they have a sufficient workforce to provide care and services, and this was observed by the Assessment Team.

The Approved Provider response indicated they have undertaken recruitment processes across all areas of this service. Recruitment has occurred for clinical and care staff, lifestyle staff, and hospitality staff. This has reduced the requirement for Agency staff and has ensured vacant shifts on the master roster are covered. Rosters have been reviewed and the Care manager is monitoring rosters to ensure appropriate skills mix is maintained.

I note the information provided for this requirement by the Assessment Team, and I acknowledge the recruitment efforts and process reviewed undertaken. I have considered information brought forward under other standards and requirements in the Assessment Team Report.

In relation to Standard 1: The Assessment Team Report included feedback from consumers and representative relating to dissatisfaction with the staff. I am not satisfied that there has been sufficient staffing to enable monitoring of staff conduct and engagement with consumers.

In relation to Standard 2: The Assessment Team Report indicated assessment and care planning has not been occurring with outstanding assessments continuing to be completed. I am not satisfied that sufficient staffing levels have been maintained to ensure the processes are completed in a timely manner.

In relation to Standard 3: The Approved Provider acknowledge that care delivery had not been satisfactory in relation to staff completing clinical monitoring activities, and The Assessment Team Report indicated that there continues to be delays in the administration of time sensitive medications. I am not satisfied there has been sufficient staffing to ensure the delivery of appropriate care.

In relation to Standard 4: The Assessment Team Report provided feedback from consumers and representatives around dissatisfaction with staff ability to assist consumers. And staff provided feedback they do not have time to complete assessments, and ensure consumers are engaged in activities. I am not satisfied there has been sufficient staffing to ensure the delivery of appropriate consumer engagement.

I have considered the information provided by the Assessment Team and the Approved Provider. My findings have been persuaded by the level of non-compliance identified in this Performance Report as well as other information outlined above as recorded under other standards in the Assessment Team Report. I find that while the Approved Provider has a planned workforce, and the mix and skills of staff is monitored, these processes have not been effective in enabling the delivery and management of safe and quality care and services. The Approved Provider has been found non-compliant with 27 requirements across all 8 standards of the Aged Care Quality Standards. The Approved Provider has also acknowledged the deficits in clinical care delivery as identified in the Assessment Team Report.

I note the recruitment that has occurred, however the effectiveness of this recruitment to enable delivery and management of safe and quality care and services has not been evaluated.

I find this Requirement is non-compliant.

Requirement 7 (3)(b)

The Assessment Team provided information that staff interactions with consumers are not always kind, caring and respectful of each consumer’s identity, culture and diversity. One consumer and 3 representatives described interactions with staff as dismissive and that care provision did not align with consumers’ specific needs. Observations and interviews with staff showed the use of disrespectful language when discussing consumers and use of unauthorised restrictive practice to manage behaviours.

For named consumers this included gender preferences not respected and staff being disrespectful.

The Approved Provider provided aresponse that included clarifying information as well as a summary from the information provided to the Commission as part of the Notice of Agree, a summary of the quality-of-life survey, critical incident reports, and policies.

In relation to a named consumer and preference for female only staff, I note the actions previously taken by the Approved Provider to address this matter and that care documentation was updated to reflect gender preferences. However, previous actions taken does not demonstrate ongoing monitoring or compliance and note the consumer provided feedback to the Assessment Team during this Site Audit that the issue is ongoing, and they continue to have male staff attending to their care on occasions. For this consumer the Approved Provider contends that events reported by the Assessment Team in regard to disrespectful behaviour is unlikely to have occurred based on the consumers’ limited physical abilities for the events recorded to have occurred.

Management has spoken with the other consumers and/or their representatives to understand their concerns and preferences and care documentation has been updated to reflect the gender preference for care.

In relation to consumers and or representatives reporting disrespectful behaviour, the Approved Provider has investigated the feedback provided. Incidents reports have been completed where required, consumers and or representatives have been contacted and matters raised have been discussed, and staff have counselled and provided education on appropriate interactions with consumers and representatives.

I have considered the information provided by the Assessment Team and the Approved Provider response.

I am not satisfied that the actions taken have demonstrated sustainable monitoring processes to ensure ongoing compliance with this requirement. I am persuaded by the feedback provided by consumers and representatives and the observations made by the Assessment Team during the Site Audit.

I find this requirement is non-compliant.

Requirement 7 (3)(c)

This Requirement was previously found non-compliant following a Site Audit in April 2023.

The Approved Provider has completed the following improvements:

* The Executive Director and Deputy Director completed training regarding restrictive practice and the Serious Incident Response Scheme.
* Implemented mandatory training days which include education topics, such as compulsory reporting, pain, falls, wounds, medication, diabetes management and restrictive practice. Records demonstrated the training days were attended by all required staff based on the nature of their working role.
* Competency packages have been developed for all clinical and care staff. Current training records demonstrate competency packages have been completed by all clinical staff in May to August 2023, however, care staff competencies were due to commence in October 2023.

The Assessment Team provided information that while members of the workforce had the appropriate levels of qualifications, they the workforce were not competent, nor had the knowledge to effectively perform their roles. This related to lack of knowledge for respectful interactions with consumers and or representatives, management of restrictive practice, management of time sensitive medications, diabetic management, and pain management.

The Approved Provider provided a response that included clarifying information as well as a training matrix, and clinical records extracts.

The Approved Provider indicated that care staff competency training packages have been provided to staff in a staged roll out and this is ongoing with staff completing relevant competencies packages.

In relation to staff knowledge of respectful behaviour, I note that staff have been provided counselling and or education, including on the organisations code of conduct. I note when required investigations into staff conduct has been conducted and staff counselled, and reflective practice undertaken.

In relation to clinical knowledge, I note the non-compliance with various requirements under Standard 2 and Standard 3, included deficits in staff knowledge or competency of assessment and care planning processes, medication management, pain management, diabetic management and restrictive practice. Whilst the Approved Provider contends that staff are aware what constitutes restrictive practice, I am not satisfied that staff demonstrated consistent knowledge of legislative requirements for the use of restrictive practice, including the requirement to obtain informed consent prior to the use of restraint. I note documentation to support the use of restrictive practice remains incomplete.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that the Approved Provider was not able to demonstrate staff have the knowledge to perform their roles effectively. I am persuaded by the non-compliance identified in this performance report, including the Approved Providers acknowledgement of deficits in care provision.

I find this requirement is non-compliant.

Requirement 7 (3)(d)

This Requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that while systems and processes for recruitment of new staff were demonstrated, training programs were not sufficient to ensure best practice care and service provision or to support staff to deliver outcomes required by these Standards. Clinical and care staff were able to describe aged care related topics, however, this was not reflected in staff practice or observations. Training records demonstrated a range of education topics had been delivered to support workers, however, not all staff had completed mandatory training, and many other modules were self-directed and not compulsory.

The Approved Provider provided a response that included clarifying information as well as training matrix, procedures and a summary of training provided.

I note the Approved Provider engaged external training providers to assist in the delivery of required training and education.

In relation to completion of mandatory training, I note the Approved Provider conducts sessions through the year and staff are allocated to attend various sessions. I note attendance is tracked for mandatory training. The Approved Provided noted gaps in previous training records, however they are focused on providing education required for 2023, as opposed to compiling previous training records.

In relation to staff knowledge of texture modified diets, the Approved Provider contends that care staff may not require knowledge specific to the international diet standards and has introduced additional processes to ensure the correct diets are provided to consumers, included updated information on diet cards and a reliance on kitchen staff to ensure correct diets are provided to consumers.

The Approved Provider has indicated that gaps in completion rates for staff training on donning and doffing personal protective equipment and hand hygiene will be addressed with all staff training for this completed by the end of 2023.

I have considered the information provided by the Assessment Team and the Approved Provider and I acknowledge that a range of education has provided to staff across areas of deficit identified at the Site Audit in April 2023. I note external training providers were contracted and delivered a range of education and training. However, I am not satisfied that the processes to monitor staff knowledge have been effective. I am not satisfied that training provided has been effective to change staff knowledge and behaviours to deliver the outcomes required by the Aged Care Quality Standards. I note the ongoing non-compliance identified in this performance report.

I find this requirement non-compliant.

Requirement 7 (3)(e)

This Requirement was previously found non-compliant at a Site Audit in April 2023.

The Approved Provider implemented the following improvements:

* Following a review of current performance review processes, the Executive Management team have made the decision to cease bi-annual performance reviews and replace them with a performance review and development tool utilised at completion of probationary employment periods for new staff.

The Assessment Team provided information that regular assessment, monitoring and review of the performance of each member of the workforce to ensure safe and quality care and services was not demonstrated.

Evidence was not provided to demonstrate staff had performance appraisals as outlined on the plan for continuous improvement in use at the time of the Site Audit. Management informed the Assessment Team that they had recently reviewed performance monitoring process and the decision had been made to cease bi-annual performance reviews and replace them with a reflective practice tool to be completed following incidents or major complaints. Reflective practice tools were demonstrated to have been used for 2 staff involved in medication incidents, however the Approved Provider did not provide the Assessment Team with reflective practice tools for staff involved in other areas of care where deficits have been identified.

Consumer feedback was provided in relation to delays with call bell response times; the Approved Provider was not able to demonstrate that trending of call bell data had been used to monitor staff providing timely care delivery.

The Assessment Team provided observations of staff practices including engaging with consumers and disrespectful behaviour towards consumers that indicated effective monitoring of staff was not occurring.

The Approved Provider provided a response that included clarifying information as well as the plan for continuous improvement.

The Approved Provider has indicated that as well as the use of reflective practice tools, performance reviews are conducted at 6 months post new employment as part of the probationary review of new staff.

The ongoing use of the reflective practice tool has been included on the plan for continuous improvement and new Clinical Staff are being trained in the use of this tool to ensure reflective practices are provided to staff relating to any performance matter.

Call bell response times have been discussed with staff and the expectations of Management has been conveyed to staff. Trending of call bell data will continue to be monitored and trends identified and discussed with staff.

Staff responsible for supervising staff have been reminded of their responsibilities and staff have been provided education about engagement with consumers.

I have considered the information provided by the Assessment Team and the Approved Provider and I find that whilst the Approved Provider had made changes to the way staff performance is assessed, monitored and reviewed, these processes are not yet effective. There has been inconsistent use of the reflective practice tool and staff continue to be educated in its use. Monitoring processes have not been effective in the Approved Provider self-identifying deficits in staff performance. I am persuaded by the non-compliance identified in this Performance Report relating to respectful interactions with consumers and representatives and deficits in the delivery of safe and effective clinical care as evidence of monitoring of staff not being effective.

I find this requirement non-compliant.

Not all Requirements in this Standard are compliant, as such the overall Standard rating is Not Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not 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. | Not 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. | Not 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. | Not Compliant |

Findings

Requirement 8 (3)(a)

This Requirement was previously found non-compliant following a Site Audit in April 2023.

The Approved Provider implemented the following improvements:

* Feedback and complaints processes explained to consumers at a Resident and Relative meeting, reinforcing the provision of consumer suggestions in the development of care and services.
* Reviewed the Feedback and Complaints Management policy to include feedback received via consumer forums as part of the internal complaints process to further identify opportunities for continuous improvement.
* A Quality-of-Life survey was conduct which included a range of care and service-related questions.

The Assessment Team provided information that consumers said they were engaged in the development, delivery and evaluation of care and services and felt supported by the service in this process. Management, clinical and care staff described how they engaged with consumers to gather feedback and suggestions across a range of care and service topics through consumer meeting forums, focus groups, surveys, and one-to-one chats to ensure care and services are tailored to meet their needs and preferences. Systems and processes are in place to capture consumers’ feedback and engage them in the development, delivery and evaluation of care and services.

I have considered the information provided by the Assessment Team and I find this requirement is compliant.

**Requirement 8(3)(b)**

This Requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that the service was unable to demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. While policies and procedures were available to all staff and recent staff training had been provided to guide staff practice, staff work practices did not align with policies and procedures, staff completion of all mandatory training remained low, and ongoing monitoring of staff performance had not been embedded into practice to ensure care and services were provided in a way that promoted a culture of safe, inclusive and quality care and services.

Management said they had developed a reporting tool to convey information across a range of care and services to the governing body, with the process commencing in September 2023. The Operations manager report for September 2023 included key information relating to staffing, internal audits, surveys, staff training and feedback and complaints. The governing body were unable to demonstrate actions taken in response to the Operations manager report as this had yet to be table at governance meetings.

The Assessment Team indicated deficits they had reported in the Assessment Team report demonstrated staff were not complying with the expectations of the governing body in relation to respectful interactions with consumers or representatives and deficits in clinical care and lifestyle programs were still occurring.

The Approved Provider provided a response that included clarifying information as well as a summary from the information provided to the Commission as part of the Notice of Agree, governance information including meeting minutes, clinical records extracts, training evaluation reports.

The Approved Provider identified reporting tools have been developed for management staff to report data and trending of data to the executives. The Approved Provider advised these reports are also tabled at the Governance meeting to ensure they are aware of the delivery of service that is occurring within the home. The reports for the previous month are due to the executive team by the middle of each month. At the time of the Site Audit the Operations manager had completed their report however the Residential Service Manager report was not completed at that time due to the Audit occurring. Management is still reviewing the data requirements for these reports and will update and amend the templates over the coming months to ensure that the information within is comprehensive covering all areas of the business. With the upgrade that is due to occur with the electronic care management system the collation of accurate data should be made easier and more transparent for Management and Executive to be able to review data. In relation to deficits in respectful staff interactions with consumers, and deficits in clinical care and lifestyle programs. As outlined under Standards,1,2, 3,and 4 the Approved Provider has engaged with individual consumers and or representatives, preferences have been captured with assessments and care plans updated as needed. Staff have been counselled and provided education in relation to the expectations of the Organisation. Ongoing matters such as providing consumers or representatives a copy of the care plan have been added to the plan for continuous improvement.

The Approved Provider has reviewed consumer feedback and the results of the quality-of-life survey and contend this does not indicate systemic issues related to staff behaviour and practice. While results are not demonstrating issues with all staff, they do recognise that there may be staff whose behaviour is not acceptable and not in line with organisation policy and contractual requirements of employment. The Approved Provider has indicated they take all feedback seriously and are working to address staff behaviour of concern with all staff. I do note the quality-of-life survey was completed by less than 50% of consumers. Additional education is being provided to staff on dignity in care. Staff behaviour is to be discussed at staff meetings and is a standing agenda item for the governance committee. Training evaluation is being conducted to ascertain changes in staff knowledge post sessions.

The Approved Provider has indicated that the new leadership team commenced in August 2023 and are responsible for monitoring staff conduct, including call bell response times. It was noted that the leadership team had been focused on call bell response times, rather than trends, however trends will now also be reviewed.

The Approved Provider contends the governing body has been actively involved in promoting a culture of safe, inclusive and quality care and services and have consistently taken accountability for the delivery of care. The governing body has been consistently supportive and ensured resources have been provided both human and material to ensure the systems that were in place prior to the site audit in April 2023 are now re-established and are being embedded in all departments and all functions. The governing body are committed to the ongoing viability of the organisation and provision of sound quality care and services.

I have considered the information provided by the Assessment Team and the Approved Provider. I acknowledge that the Approved Provider is taking actions to ensure the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. This includes recruitment of a new leadership team, establishing reporting arrangements to the governing body and conducting governance meetings. However, the sustainability and effectiveness of these initiatives are yet to prove effective.

I am persuaded by the level of non-compliance identified in this Performance Report as indicating that the systems and process to ensure accountability are not effective.

I find this requirement non-compliant.

**Requirement 8 (3)(c)**

This requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that while systems and processes for financial governance and feedback and complaints were demonstrated, deficits identified at the Site Audit in April 2023 relating to information management, continuous improvement, workforce governance and regulatory compliance remain ongoing.

For information management this included deficits in processes to assess, plan, document and monitor care, monitoring incidents and staff practices had not been sufficiently utilised to identify trends, some incident data was identified by the Assessment Team to be incorrect, high risk resident review and management meeting minutes lacked adequate levels of information to demonstrate appropriate action taken to manage high risk care needs, and consumers’ private information had been shared without their consent.

For continuous improvement the organisation has continuous improvement systems and processes, however only 17 improvements have been fully implemented since the Site Audit in April 2023. There are 73 improvement actions which remain ongoing; however, the governing body has been unable to demonstrate they regularly review continuous improvement progress.

Workforce governance systems and process were identified as insufficient in guiding staff practice in the provision of safe and quality care and service, with staff practice not aligning with policies and procedures, insufficient monitoring of staff performance, and poor staff completion of all mandatory training.

For regulatory compliance the organisation had systems and process to track and respond to regulatory compliance changes, and ensure organisational policies and procedures align to regulatory and legislative requirements and reflect best practice. Staff were educated on key areas of care with specific legislative responsibilities; however, this was not sufficient to ensure all regulatory obligations were met, including restrictive practices implemented without appropriate assessment, authorisation, and consent, and did not align with the requirements outlined in the Quality of Care Principles 2014.

The Approved Provider’s response included clarifying information as well as meeting minutes, extracts of clinical records, care evaluation reports, plan for continuous improvement, training matrix.

The Approved Provider had indicated that ongoing glitches with the electronic care management system has resulted in challenges to obtain accurate data in a timely manner, a system upgrade had been scheduled for November 2023 to address the glitches and accurate data for trending would be obtainable.

The Approved Provider has reviewed the High-Risk Resident Review and Management meeting, and a new reporting template is due to be introduced which includes an action list to track and monitor consumers of concern.

The Approved Provider contends that the Governing body is provided accurate and contemporary information, and the Care Manager is completing a monthly report for Clinical Incident analysis and trending which goes to the Clinical Governance Committee and Governance Committee. While noting that improvements are being made to the electronic care management system to improve data collection. Any discrepancies in data had been due to the known glitches in the electronic care management system. Both the Director and Associate Director, and management staff are aware of the need to ensure reporting to the Governing body is timely and accurate and informs them.

The Approved Provider acknowledges that confidential information had been inadvertently shared with consumer’s representatives and staff had been counselled over this.

The Approved Provider indicated that the management team regularly review the plan for continuous improvement and update as required. Any updates and changes are identified in the progress/outcomes column and notes a date of review or update. The Approved Provider has also used action plans to address the non-compliance previously identified at the Site Audit in April 2023.

For workforce governance, the Approved Provider has undertaken significant recruitment and has reduced vacant shifts and reliance on Agency staff over the past 6 months. A new leadership team, additional clinical, hospitality and lifestyle have been recruited. There are now minimal vacant shifts and a reduced requirement for Agency staff. Mandatory training is planned to occur over time, to reduce education overload on staff, attendance is being monitored.

The Approved Provider has introduced a reflective practice tool and has been conducting investigations into staff conduct following incidents and complaints and is conducting counselling and additional education sessions relating to respectful staff interactions and staff engagement with consumers.

The Approved Provider is working with external support agencies to assist in the development in behaviour support plans and is completing restrictive practice assessments and gaining informed consent as required under the Quality-of-Care Principles 2014.

I have considered the information provided by the Assessment Team and the Approved Provider.

In relation to information management, I find that there are ongoing deficits relating to information management, including ensuring accurate information is available to staff to deliver care and services, with inconsistent completion of assessments and care planning.

In relation to continuous improvement, I note the Approved Provider has completed some improvements to address deficits following the Site Audit in April 2023, are responsive to feedback and are maintaining a plan for continuous improvement. I find that processes to monitor ongoing compliance with the Aged Care Quality Standards is not effective. The Approved Provider is not consistently self-identifying deficits within systems and process to ensure compliance.

In relation to regulatory compliance, I find the Approved Provider has not met their requirements under the Quality-of-Care Principles 2014 in relation the management of restrictive practice.

I am persuaded by my findings outlined above that there are not effective organisation wide governance systems in operation.

I find this requirement is non-compliant.

**Requirement 8 (3)(d)**

This Requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that the service did not demonstrate effective risk management systems and practices were in place for the management of high impact or high prevalence risk, identifying and responding to abuse and neglect, and the management and prevention of incidents, or supporting consumers live their best life.

High-risk resident review and management meetings to discuss and review consumers identified to experience falls, pain, have current wounds, and weight loss have been implemented; meeting minutes contain insufficient information to demonstrate actions being taken by the service to manage consumers’ high impact or high prevalence risks. The Assessment Team provided information of inconsistent collection and reporting of clinical incident data.

In relation to identifying and responding to abuse and neglect, the Assessment Team identified staff practice including use of seclusion and unauthorised restraint use.

In relation to supporting consumers live the best life they can, the Assessment Team identified deficits in consumers being able to exercise choice, and deficits in the provision of care, including end of life care. And deficits in supporting consumer to engage in activities and move freely around the service.

The Approved Provider’s response included clarifying information as well as high risk meeting minutes, and high risk guidelines for staff.

The Approved Provider advises they have implemented a new reporting template planned which includes an action list which will give broader follow up by the Clinical team and enable more monitoring of decline or High-risk areas, that will ensure comprehensive details are consistently documented. Upgrades to the electronic care system will allow for improved incident reporting and data collection, to manage high impact and high prevalence risks. This includes providing accurate reports to the clinical governance committee and Governing board.

The Approved Provider is developing a training module for the care staff to assist them with incident reporting. The upgraded electronic care management system will assist with updated assessments and reports. Reporting of Incidents is also highlighted during meetings and handover.

The Approved Provider has noted that seclusion is not practiced at the service and ‘quiet time’ for a consumer is part of effective behaviour management. Restrictive Practice assessments continue to be completed and were awaiting medical officer authorisation at the time the Approved Provider submitted their response.

The Approved Provider acknowledges some of the deficits in relation to provision of care to consumers, I note this had an impact on the consumer being able to live the best life they could.

I have considered the information provided by the Assessment Team and the Approved Provider. I find there are not effective risk management systems and practices. I am persuaded by the deficits in the management of high impact and high prevalence risks to consumers as outlined in the finding of non-compliance in Requirement 3 (3)(b) as well as the information presented in the Assessment Team report. I note that the Approved Provider is implementing improvement actions, however these remain in action and have yet to be evaluated for sustainability and effectiveness.

I find this requirement is non-compliant.

**Requirement 8 (3)(e)**

This requirement was previously found non-compliant following a Site Audit in April 2023.

The Assessment Team provided information that while effective antimicrobial stewardship and open disclosure processes were demonstrated, organisational clinical governance systems were not effective to ensure consumers were provided with safe and quality clinical care. A Clinical Governance Committee has been established and the Clinical Governance Framework is under review. Clinical staff were completing the new clinical incident reporting tool, and this would be tabled at the next Clinical Governance meeting.

Clinical Governance meeting minutes from September 2023 demonstrated action taken by the Clinical Governance Committee to address issues with the administration of time sensitive medications, however, the Assessment Team identified issues regarding administration of these types of medications remain ongoing.

Clinical Governance processes were not effectively identifying restrictive practice use, specifically, all consumers at the service subject to restrictive practices and the use of unauthorised restrictive practice, such as the unauthorised use of mechanical restraint and seclusion. Behaviour support plans were generic in nature and did not identify potential triggers or include sufficient information to support effective behaviour management and reduce the need for restrictive practice use.

The Approved Provider’s response included clarifying information as well a Clinical Governance meeting minutes outstanding actions list, and other governance reports.

The Approved Provider indicated that an interim Clinical Governance Committee was in operation since the Site Audit in April 2023 and clinical reports were being provided to the Governing body during this time. An outstanding governance actions list is maintained, and actions are being implemented. The electronic care management system is being upgraded to facilitate the collection of accurate data.

The Approved Provider noted that behaviour support plans have been reviewed and an external support agency has been working with the Clinical staff in the assessment, and management of some consumers, with behaviour support plans being updated.

The Approved Provider did not agree that staff did not know what constituted restrictive practice and noted that ongoing work is continuing with ensure assessment and authorisations for the use of restrictive practice is consistently occurring.

I have considered the information provided by the Assessment Team and the Approved Provider and I acknowledge that the Approved Provider has a Clinical Governance Committee, that reports are being produced and provided to the governing body on clinical issues. I note the Assessment Team identified that effective antimicrobial stewardship and open disclosure processes were demonstrated.

However, I am not satisfied that there are effective governance processes to monitor actions undertaken and for the effective governance of the use of restrictive practice. In determining my findings, I am persuaded by the ongoing deficit in the management of time sensitive medications following actions taken by the Governance Committee, as well as a failure to identify that the assessment and authorisation of restrictive practice was not consistently occurring.

I find this requirement non-compliant.

Not all Requirements in this Standard are compliant, as such the overall Standard rating is Not Compliant.

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