Geegeelup Aged Care Facility

Performance Report

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**Commission ID:** 7127

**Provider name:** Geegeelup Aged Care Facility

**Site Audit date:** 3 May 2022 to 5 May 2022

**Date of Performance Report:** 17 June 2022

# Performance report prepared by

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

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the Site Audit report received 25 May 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Quality Standard is assessed as compliant as six of the six specific Requirements have been assessed as compliant.

Consumers considered they are treated with dignity and respect, can maintain their identity and live the life they choose. Consumers said they are supported and encouraged to do things for themselves and provided examples of how their privacy is maintained by staff, how their care and services are culturally safe and how they are supported to exercise choice, take risks and maintain relationships.

Staff spoke about consumers in a respectful manner, described their life history, background and preferences, and provided examples of how they are considered to ensure care and services are culturally safe. Staff explained how they maintain consumers’ privacy and support consumers to maintain independence, exercise choice and take risks. Staff were observed interacting with consumers in a respectful, warm and friendly manner.

Sampled care plans were personalised and documented strategies for staff to support them in taking risks.

Interviews with consumers and staff demonstrated consumers are provided information to assist in making choices regarding meals, activities and their personal and clinical care.

Based on this evidence, I find the service compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirement (3)(a) in Standard 2, as the service was unable to demonstrate that assessment and planning for three sampled consumers included consideration of risks to their health and well-being to inform the delivery of safe and effective care and services.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service non-compliant with Requirement (3)(a). I have provided reasons for my findings under the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers confirmed they feel like partners in the ongoing assessment and planning of their care and services.

All consumer files sampled identified and addressed consumers’ needs, goals and preferences relating to care and services, including advance care planning and end of life planning.

Consumers and representatives stated, and care files demonstrated, staff work with the consumer and/or representative to ensure care and service provision is in line with consumers’ needs and preferences. Involvement of other providers of care, including Medical officers and Allied health professionals was also noted.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers and documented in a care plan which assists staff to deliver care and services in line with consumers’ preferences. Consumers and representatives demonstrated an awareness of how to access consumers’ care plans and confirmed outcomes of care planning are communicated with them clearly and in a timely manner. Staff provided examples of how they have communicated outcomes of care planning to consumers who have cognitive impairment.

Care planning documentation demonstrated regular review of consumers’ care and service needs and preferences periodically, and in response to change in condition and incidents.

Based on this evidence, I find the service to be compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found the service has structured processes for assessment and planning, and appropriately uses validated risk assessment tools to identify risks related to choking, falls and malnutrition. However, the Assessment Team was not satisfied the service 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, specifically in relation to pressure injury staging, bowel management and medication administration. The Assessment Team provided the following evidence relevant to my finding:

* Classification and description of one consumer’s pressure injury on their wound chart was stage two and black, which was inconsistent with the pressure injury classification system used by the service. The wound chart did not state the type of wound, showed incomplete assessment of the wound and there were gaps in relation to frequency of dressing changes. One staff was unaware the consumer had a wound and on review, stated it was most likely stage three, four or unstageable.
* Ineffective assessment of one consumer’s constipation resulted in significant delay of escalation to a Medical officer and implementation of appropriate interventions.
  + Prior to the consumer’s change in bowel pattern, documentation showed they were commenced on transdermal pain medication which can cause severe constipation when used for prolonged periods.
  + The consumer’s bowel chart noted they opened their bowels but states it was unseen. The consumer has advanced dementia and staff said they cannot rely on them for effective assessment of constipation.
  + Despite displaying ongoing discomfort, including feeling sick, dry retching, burping, restlessness, nausea and meal refusal, a Medical officer was not contacted for 14 days after their bowels last opened. During this 14-day period, interventions to aid evacuation were only provided on two occasions. The consumer was subsequently transferred to hospital.
  + Upon return from hospital, the consumer’s medications were reviewed, strategies to ensure bowel evacuation were implemented and monitoring of bowel movements occurred.
* Documentation showed the service failed to refer one consumer to a Medical officer for assessment and review, despite being administered more than 200 doses of as required sedatives, analgesia and antiemetics, over a three-month period.
  + The organisation’s medication policy states when as required medication is administered on two occasions over three days, the use of the medication must be referred to a Medical officer for review.

The provider acknowledges deficits identified by the Assessment Team and the provider’s response includes evidence demonstrating action taken in response, including, photographing existing wounds, implementing a ‘bowels not open’ column in charting, care plan reviews, recruitment of additional staff and updating medication policies procedures.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate assessment and planning, including consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services.

I have considered that one consumer’s wound was incorrectly staged, wound charting did not document the type of wound and showed incomplete assessment of the wound. While there was no evidence indicating the wound was not effectively managed, I find these failures resulted in a lack of planning to guide staff in providing safe and effective care congruent to the severity of the wound.

I have also considered that assessment and planning processes were not effective to guide staff in relation to risks associated with one consumer’s inability to open their bowels. The service did not plan for and document strategies to guide staff in managing potential constipation following administration of medication, of which constipation is a known side effect. Staff were therefore relying on the consumer to advise when their bowels had opened, however, the consumer has severe cognitive impairment and could not be relied upon for effective assessment of constipation. These ineffective processes resulted in delays in escalation to a Medical officer and subsequent transfer to hospital.

In relation to medication management, I have considered that assessment and planning processes did not identify and inform care delivery for one consumer who was administered significant volumes of as required sedatives, analgesia and antiemetics. Despite being administered more than 200 doses of as required medication over a three-month period, referrals were not made to a Medical officer for assessment and review in line with the organisation’s policy.

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as non-compliant as one of the seven specific Requirements has been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirement (3)(a) in Standard 3, as the service was unable to demonstrate each consumer gets safe and effective care that is best practice, tailored to their needs, and optimises their health and well-being, specifically in relation to medication, continence and pain management.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service non-compliant with Requirement (3)(a). I have provided reasons for my findings under the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered they receive personal and clinical care that is safe and right for them.

Documentation and interviews with staff showed effective management of high impact or high prevalence risks associated with the care of consumers, including diabetes and wounds. Key risks associated with the care of sampled consumers were recorded in care planning and handover documentation. The organisation has policies and procedures to guide staff in relation to management various areas of risk.

The service has processes to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, with their comfort maximised and their dignity preserved. A representative of a consumer who had recently passed away provided positive feedback about their family member’s palliative care. Care conferences are completed in consultation with consumers and/or representatives upon identification of deterioration to ensure specific cultural, religious, spiritual, social and psychological aspects of care are met.

Consumers and representatives reported changes to consumers’ health are identified and responded to promptly. Care files sampled demonstrated assessment and monitoring processes are implemented and referrals to relevant health professionals initiated. The organisation has policies and procedures to support staff in recognising and responding to deterioration or change in consumers’ condition.

Interviews with consumers, representatives and staff, and documentation showed information about the consumer is adequate and accessible to support safe and effective care and service delivery.

The service demonstrated infection control measures are in place, and staff were able to describe the steps they take to minimise spread of infection. While clinical staff said they had not completed infection reports recently, they said they work in collaboration with a Medical officer to ensure appropriate prescribing of antibiotics.

The service recently experienced a Rhinovirus outbreak, which resulted in minimal spread due to timely implementation of their Outbreak management plan. After the outbreak had ceased, a post-outbreak review was conducted and changes to infection control strategies were implemented.

While the service has an appointed Infection prevention and control lead, they have not undertaken recognised training to ensure they have the knowledge and skills to undertake their role. This has been considered under Requirement (3)(c) in Standard 7 Human resources.

Management reported the service does not have a process for collating and analysing data in relation to microbials, in line with the organisation’s policies and procedures. This has been considered under Requirement (3)(e) in Standard 8 Organisational governance.

Based on this evidence, I find the service to be compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team was not satisfied the service demonstrated each consumer gets safe and effective care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to medication, continence and pain management. The Assessment Team provided the following evidence relevant to my finding:

Medication management

* Documentation shows over the three months prior to the Site Audit, one consumer was administered as required analgesia, sedatives and antiemetics on 209 occasions to treat pain, anxiety and insomnia. Despite a three-fold increase in some of the medication over a three-month period, escalation to a Medical officer did not occur as required under the organisation’s policy.
  + The organisation’s medication policy states when as required medication is administered on two occasions over three days, the use of the medication must be referred to a Medical officer for review.
  + Documentation shows a three-fold increase in administration of sedatives (six, 20 and 21 doses in February to April 2022 respectively) over the three months, however, management were unaware this had occurred and confirmed staff should have discussed this at shift handover.
  + Management confirmed there is no formal process to review as required medication.
  + The service’s process in relation to the administration of as required medication was not followed, as the reason, time of administration and effectiveness of medication was not consistently recorded.
  + The Medical officer stated they had not been made aware of an increase in medication and confirmed it is something they would need to know.
  + The consumer does not feel their symptoms are managed well, as they constantly feel ‘giddy’ and when looking at the Assessment Team’s face, saw ‘two pairs of eyes and ears.’
* Documentation showed clinical guidance is not sought from ‘medication competent’ care staff when administering as required medication, to ensure they are administered safely.
  + The organisation’s policy states that a ‘medication competent’ carer can administer as required medication, however, prior to administration, an assessment of the consumer’s needs is required to ensure it matches with the reasons for prescription.
  + ‘Medication competent’ care staff administered three different as required medications to a consumer within one hour because they were unsettled. There was no evidence indicating nursing guidance was sought to ensure appropriate medication was administered based on the consumer’s condition.
  + Medication competent care staff did not consult with clinical staff following administration of pain medication which only had some effect.

Continence care

* Documentation showed there was a delay in identifying and responding to one consumer’s constipation to ensure successful bowel evacuation.
* Bowel charting showed the consumer had not opened their bowels for two weeks, which resulted in being transferred to hospital due to severe constipation.
* Prior to the consumer’s change in bowel pattern, documentation showed they were commenced on transdermal pain medication which can cause severe constipation when used for prolonged periods.
* Progress notes show interventions to aid evacuation were administered five days after no bowel movement, however, there was no follow through from clinical staff for a further two days, when the next intervention was administered. Additionally, staff incorrectly documented the number of days the consumer’s bowels had not opened.
* Progress notes show the consumer experienced ongoing discomfort from days five to 13 after their bowels had last opened, including feeling sick, dry retching, burping, restlessness, nausea and meal refusal. The consumer also struck one staff which was not in line with their typical behaviour. However, this did not trigger escalation to a Medical officer.
* Fourteen days after the consumer’s bowels had not opened, a Medical officer was contacted, and the consumer was subsequently transferred to hospital.
* Upon return from hospital, the consumer’s medications were reviewed, strategies to ensure bowel evacuation implemented and monitoring of bowel movements has occurred.
* The Medical officer said ‘it took a while’ for staff to recognise the severity of the consumer’s constipation.

Pain management

* One representative expressed dissatisfaction with their family member’s pain management following a fall. The representative stated despite having four fractures and being in severe pain, the consumer was not transferred to hospital for pain management for four days.
* Progress notes confirmed the consumer was offered hospital transfer immediately after the fall, which they declined.
* Progress notes show the consumer was administered two doses of as required opioid over two days after the fall.

The provider acknowledges deficits identified by the Assessment Team, however, the provider’s response includes further information in relation to the medication management aspects of the Assessment Team’s assertions.

In relation to the consumer who was administered as required analgesia, sedatives and antiemetics on 209 occasions over a three-month period, a Plan of care – Minimise use of psychotropic medications and consent form was provided, which demonstrates Medical officer directives in relation to the prescribed sedative was for infrequent use and to be used as a last resort when all non-pharmacological interventions to treat insomnia have failed.

The response also includes evidence demonstrating action taken in response, including, implementing a ‘bowels not open’ column in charting, care plan reviews, recruitment of additional staff and updating medication policies procedures.

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

I have considered that Medical officer directives for ‘infrequent use’ of sedatives for one consumer were not followed, as 20 and 21 doses were administered in March and April 2022 respectively. The three-fold increase in the administration of as required medication was not identified or escalated to a Medical officer, to ensure best practice and tailored care was provided to optimise the consumer’s health and well-being. While satisfied with their care overall, the consumer felt their symptoms were not well managed.

In relation to medication administration, I have considered that ‘medication competent’ staff did not seek clinical guidance prior to administering as required medication in line with the organisation’s policy. On two occasions, there was no evidence clinical guidance was sought even after medication was administered, despite medication having no or minimal effect.

I have also considered safe and effective continence care was not provided to one consumer who experienced severe constipation. Despite interventions to excavate their bowel being ineffective and the consumer displaying signs of extreme discomfort, the consumer was not referred to a Medical officer until two weeks after their last bowel movement.

In relation to pain management, I have considered that while one representative was dissatisfied their family was not transferred to hospital, evidence demonstrated the consumer was offered a hospital transfer but refused. While the consumer was subsequently transferred to hospital, there was no evidence indicating they had unmanaged pain from the time of the fall until they were transferred to hospital.

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

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

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

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

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

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

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as compliant as seven of the seven specific Requirements have been assessed as compliant.

Consumers consider the service supports them to do the things they want to do, and which are important for their health and well-being. For example:

* consumers provided examples of the support they receive to meet their needs, goals and preferences, including emotional needs, and enable them to do the things they want to do;
* consumers stated the service ensures their condition, needs and preferences are communicated within the organisation, and with others where responsibility is shared;
* consumers provided examples of when they have accessed external providers of care and services;
* consumers were satisfied with the quality and variety of meals provided; and
* consumers were satisfied with equipment used to manage their safety and comfort.

Staff provided examples of how services are tailored to consumers’ individual needs, and how consumers are supported to maintain independence and engage in activities to promote their emotional, spiritual and psychological well‑being. Catering staff demonstrated an understanding of consumers’ dietary needs and preferences.

The following observations were made:

* on each day of the Site Audit, consumers were participating in a range of activities and spending time with visitors in communal areas;
* equipment to facilitate activities, including craft materials, quiz books and reading materials were available for consumers to use;
* the kitchen appeared clean and organised; and
* equipment appeared clean and well-maintained.

Care plans were found to document information about consumers’ emotional, spiritual and psychological well-being, in addition to their needs and preferences, history, interests and dietary requirements. Consumer files showed timely and appropriate referrals to individuals, organisations and providers of other care and services for the provision of lifestyle support.

Lifestyle documentation showed group activities are diverse and individualised activity options are available.

Based on the above evidence, I find the service compliant with all Requirements in Standard 4 Services and supports for daily living.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The Quality Standard is assessed as compliant as three of the three specific Requirements have been assessed as compliant.

Consumers feel they belong and feel safe and comfortable in the service environment. Consumers reported the environment is clean and well‑maintained, they are free to use communal areas and regular feedback is sought about how the environment can be improved. Consumers also confirmed the furniture and equipment they use is clean, well-maintained and suitable for their needs.

The environment was observed to be welcoming with individual rooms decorated with memorabilia, photographs and other personal items, clean and well maintained. The layout of the service enabled consumers to move around freely, with suitable furniture, fittings and signage to help consumers navigate the service. Consumers had ready access to tidy outdoor areas with gardens, benches and communal tables, and paths that enabled free movement around the area.

Policies and procedures described systems for the purchase, service and maintenance of furnishings and equipment and how environmental related risks to consumers were identified and managed. Staff interviewed confirmed their understanding of the systems and maintenance arrangements.

Based on the above evidence, I find the service compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

The Quality Standard is assessed as compliant as four of the four specific Requirements have been assessed as compliant.

Consumers consider they are encouraged and supported to give feedback and make complaints, and appropriate action is taken to address feedback and complaints. Consumers reported they feel comfortable providing feedback or making a complaint, are aware of advocacy and language services available, are confident appropriate action would be taken and provided examples where their feedback and complaints have resulted in satisfactory changes.

Staff demonstrated an awareness of the range of feedback mechanisms and described how they assist consumers in making a complaint and providing feedback and apply principals of open disclosure.

Management provided examples of how feedback is actioned to improve care and service delivery for consumers.

The organisation has policies and procedures in relation to open disclosure to guide staff practice.

Based on the evidence above, I find the service compliant with all Requirements in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

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

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

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Quality Standard is assessed as non-compliant as one of the five specific Requirements has been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirements (3)(c) and (3)(e) in Standard 7, as the service was unable to demonstrate:

* the workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles; and
* regular assessment, monitoring and review of the performance of each member of the workforce.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service non-compliant with Requirement (3)(c) and compliant with Requirement (3)(e). I have provided reasons for my findings under the specific Requirements below.

In relation to all other Requirements in this Standard, the Assessment Team found consumers and representatives considered staff interactions with consumers were kind, caring and respectful.

The service has processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. Management described how they ensure staffing levels are sufficient and address unplanned leave. Call bell data is not regularly collected or analysed to understand whether staffing numbers are adequate to meet consumers’ needs and most consumers and representatives felt there could be more staff, however, they did not describe any adverse impact.

Staff interactions with consumers were observed to be kind, caring and respectful, and staff demonstrated knowledge of consumers’ identity, culture and diversity. Feedback data for February 2022 included positive comments from consumers and representatives regarding how staff go above and beyond and are compassionate when providing care.

A training schedule is maintained and is based on performance appraisal, incident and feedback data. Management said there has been a focus on training due to an influx of new staff and processes are in place to ensure staff have appropriate certifications relative to their role. The training and education matrix show staff training is tracked and followed up when overdue.

Based on the evidence above, I find the service compliant with Requirements (3)(a), (3)(b) and (3)(d) in Standard 7 Human resources.

## Assessment of Standard 7 Requirements

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

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

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

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

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

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

The Assessment Team was not satisfied the service demonstrated the workforce is competent and have the qualifications and knowledge to effectively perform their roles, specifically in relation to medication administration. The Assessment Team provided the following evidence relevant to my finding:

* Documentation showed the organisation’s policies were not being followed in relation to medication administration.
  + The organisation’s policy states an Enrolled nurse, or a carer cannot make the decision to administer a Schedule 8 drug and requires consumers to be assessed by a Registered nurse prior to medication administration
  + For consumers who are administered as required medication on two occasions over three days, the organisation’s policy requires staff to seek a Medical officer review.
  + Multiple consumers received regular doses of as required medications without being escalated to clinical staff or a Medical officer for review in line with the organisation’s policy.
  + One consumer was administered benzodiazepine medication almost daily, without consultation from a Registered nurse. The Assessment Team noted a three-fold increase over a three-month period, however, management and the Medical officer were not aware the consumer’s medication had increased.
  + As consultation from a Registered nurse was not obtained, one consumer was administered more than their prescribed dose of as required opioid medication.
* Documentation showed ‘medication competent’ carers did not appropriately evaluate the effectiveness of as required medication when clinical supervision was unavailable and escalate accordingly.
  + Escalation to clinical staff or a Medical officer did not occur for consumers who received as required pain medication which was evaluated as ineffective.
  + Consumers’ care prior and post medication administration was not consistently documented.
* Staff did not identify or escalate one consumer’s severe constipation until two weeks after their bowels had last opened despite the consumer demonstrating severe discomfort, including feeling sick, dry retching, burping, restlessness, nausea and meal refusal.
* Management reported they are responsible for providing clinical oversight and supervision to clinical staff, developing and implementing policies and procedures, investigating incidents and acting as an Infection prevention and control lead. Management acknowledged completion of these tasks within part time hours is a challenge and it has been escalated for consideration.
* Whilst the service has a designated Infection prevention and control lead, they have not completed an identified infection prevention and control course.

The provider acknowledges deficits identified by the Assessment Team and the provider’s response includes evidence demonstrating action taken in response, including, implementing a ‘bowels not open’ column in charting, recruitment of additional staff, updating medication policies procedures and scheduling training.

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

Carers who are ‘medication competent’ did not have the knowledge or capability to seek clinical guidance when as required medication was ineffective or follow the organisation’s policy prior to administration of Schedule 8 medication. This resulted in multiple types of medication being administered within a short period, potential unmanaged pain, medication errors, failure to request Medical officer reviews, and management and the Medical officer being unaware of consumers’ changing conditions.

Staff did not have the knowledge or capability to identify or escalate one consumer’s severe constipation until two weeks after their bowels had last opened, despite the consumer demonstrating severe discomfort.

The service’s Infection prevention and control lead has not completed an identified infection prevention and control course to ensure they can effectively support, design and implement continuous improvement of infection prevention policies, procedures and practices and undertake outbreak management planning and preparedness.

I have placed weight on feedback from management that they find providing clinical oversight and supervision to clinical staff to be challenging within part-time hours.

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

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

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

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

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

The Assessment Team found the service has processes in place to review staff performance, however, they were not satisfied these processes were effective, as deficits were identified in relation to medication administration, wound classification, and bowel management. The Assessment Team provided the following evidence relevant to my finding:

* Management said all staff are to have completed a performance appraisal with their supervisor by the end of the financial year and trends identified through this process are used to inform the training schedule.
* Staff described the appraisal process and said they could raise issues regarding any training they feel they need.
* The performance appraisal timetable showed 18 staff are still required to have a performance appraisal, however, they have been scheduled.
* The process for regular assessment, monitoring and review of each member of the workforce did not identify ‘medication competent’ carers were acting outside their scope of practice and were not escalating as required medication usage in line with the organisation’s policy, that Registered nurses were not monitoring the process of medication delegation and were not accurately applying wound classification procedures, and staff did not effectively manage and escalate one consumer’s constipation.

The provider acknowledges deficits identified by the Assessment Team and the provider’s response includes evidence demonstrating action taken in response, including, recruitment of additional staff to provide greater clinical oversight and updating medication policies procedures.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service demonstrated regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I have considered that while monitoring processes did not identify incorrect staff practice in relation to medication administration, wound classification and bowel management, it is not proportionate to suggest the service’s performance management processes are ineffective on these factors alone. I acknowledge there are areas for improvement in the service’s performance management processes to ensure deficiencies in staff practice are identified across all areas of care, however, the evidence in the Assessment Team’s report is more reflective of staff competency, therefore, has been considered under Requirement (3)(c) in this Standard.

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as non-compliant as two of the five specific Requirements have been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirements (3)(c), (3)(d) and (3)(e) in Standard 8, as the service was unable to demonstrate:

* effective organisation wide governance systems relating to information management and workforce governance;
* effective risk management systems and practices in relation to incident management; and
* a clinical governance framework, specifically in relation to medication administration, antimicrobial stewardship and minimising the use of restraint.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service compliant with Requirement (3)(c) and non-compliant with Requirements (3)(d) and (3)(e). I have provided reasons for my findings under the specific Requirements below.

In relation to all other Requirements in this Standard, the Assessment Team found consumers and representatives are supported, engaged and are partners in the provision of care, they feel comfortable speaking with staff and described various ways they are able to provide feedback and suggestions.

Documentation showed the organisation’s governing body is accountable for and promotes a culture of safe, inclusive and quality care and services by overseeing key performance indicators, incidents, complaints and continuous improvement.

Based on the evidence above, I find the service compliant with Requirements (3)(a), (3)(c) and (3)(b) in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The Assessment Team found the service demonstrated organisation wide governance systems were effective in relation to financial governance, continuous improvement, regulatory compliance and feedback and complaints. However, the Assessment Team was not satisfied the service demonstrated effective governance systems in relation workforce and information management. The Assessment Team provided the following evidence relevant to my finding:

* Staff reported they were in the process of updating care plans to improve accessibility and an electronic system for accessing policies and procedures has been implemented, which is a significant improvement.
* Processes of information transfer were not effective to ensure management have clinical oversight and are able to identify deficits in staff practice, as the frequency of as required medication was not being communicated to management and the Medical officer.
* The service has a Plan for continuous improvement which is overseen by the Board. Actions are identified from consumer and staff feedback and are mapped against the Quality Standards. However, as the service does not have robust processes for incident investigation, opportunities for improvement may be missed. This has been considered under Requirement (3)(d) in this Standard.
* Management said the service has processes to escalate requests for expenditure outside their planned budget and they are proactive in applying for special grants and funding to improve the service environment. Management provided examples of where this has occurred in response to feedback from consumers and staff.
* Workforce governance systems ensure there are adequate numbers of staff to ensure safe and effective care and services is provided to consumers. However, monitoring processes did not identify deficits in staff practice in relation to medication and bowel management, and wound classification.
* Interviews with staff and management, and documentation shows staff have received training in relation to the Serious Incident Response Scheme (SIRS) and booklets have been created to support staff in understanding the respective legislation.
* The service was contacted by the Aged Care Quality and Safety Commission, as reportable SIRS incidents had not been recorded. In response, the service conducted a review to ensure all incidents were reported in line with their regulatory obligations and further training was provided to staff. However, there was no evidence indicating investigation was undertaken and actions implemented to prevent reoccurrence in relation to the one reportable medication incident identified through this review. This has been considered under Requirement (3)(d) in this Standard.
* The service’s Infection prevention and control lead has not completed an identified Infection prevention and control course.
* Consumers and representatives felt supported to provide feedback and complaints. Management described a range of methods used to encourage consumers and representatives to provide feedback and make complaints.

The provider acknowledges deficits identified by the Assessment Team and the provider’s response includes evidence demonstrating action taken in response, including, consideration of using an electronic incident reporting system, recruitment of additional staff to provide greater clinical oversight and updating medication policies procedures.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate that at the time of the Site Audit, the organisation’s governance systems in relation to information management and workforce governance was ineffective.

In relation to information management, I have considered that while evidence in the Assessment Team’s report demonstrates consumer information was not consistently communicated by staff to management and the Medical officer, this is not indicative of deficits in the organisation’s information management systems. The intent of this Requirement is to ensure the organisation has effective systems in place to give members of the workforce access to information that helps them in their roles, that consumers have access to information about their care and services, and ensure information is being adequately stored, maintained, shared and destroyed. The service has demonstrated governance systems in relation to information management are robust, as areas for improvement have been self-identified and actions have been implemented, such as improved access to care plans, policies and procedures, to ensure consumers and staff have the right information when they need it. As the issues identified by the Assessment Team relate to competency of staff, I have considered the evidence under Requirement (3)(c) in Standard 7 Human resources.

In relation to workforce governance, I have considered that while monitoring processes did not identify incorrect staff practice in relation to medication administration, wound classification and bowel management, there is no evidence indicating how the organisation’s governance systems failed. I find it is not proportionate to suggest the organisation’s governance systems are ineffective based on these factors alone. I have considered evidence in the Assessment Team’s report under Requirements (3)(a), (3)(d) and (3)(e) in this Standard, which demonstrates robust governance systems in relation to the number and mix of workforce deployed, recruitment and training of staff, and performance management processes.

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

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

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

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

The Assessment Team found the service has an effective risk management framework, including systems and practices that guide staff in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and supporting consumers to live the best life they can. However, the Assessment Team was not satisfied risk management systems and processes were effective in relation to managing and preventing incidents. The Assessment Team provided the following evidence relevant to my finding:

* Documentation showed incidents are not consistently investigated or being used to drive continuous improvement or prevent similar incidents from occurring. For example:
  + One ‘medication competent’ carer did not follow organisational policies and procedures and administered more opioid pain medication than was prescribed to one consumer at end-of-life. The event was identified and investigated through incident management processes, however, the investigation did not include any follow up action to review staff skills and knowledge, pain management, end-of-life and escalation processes, and staff access to medications.
  + The service did not investigate one consumer’s fall which resulted in multiple broken bones and fractures and contributed to their clinical deterioration and subsequent death. While the incident was reported through the service’s incident management system, the underlying causes of the incident were not investigated to identify whether it could have been prevented and whether measures could be implemented to reduce the occurrence of similar incidents in the future. Additionally, the service was unaware the representative was dissatisfied with the consumer’s post fall pain management and processes for hospital transfer.
  + In relation to an incident where one consumer was administered incorrect medication, the cause was investigated, and relevant staff spoken to, however, no further action was taken. There was no evidence indicating a review of processes was conducted or action was taken to prevent reoccurrence.

The provider acknowledges some aspects of deficits identified by the Assessment Team and the provider’s response includes evidence demonstrating action taken in response, including, consideration of using an electronic incident reporting system, recruitment of additional staff to provide greater clinical oversight and updating medication policies procedures.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates that at the time of the Site Audit, the organisation’s risk management systems were not effective in relation to managing and preventing incidents.

I acknowledge that incident management processes are generally being followed by staff in relation to logging and recording incidents, however, I have considered that incidents are not used to identify opportunities for improvement and prevent them from reoccurring in the future. In relation to the three sampled consumers, a review of organisational processes and procedures that may have contributed towards the incidents was not undertaken to implement improvements, minimise risk and ensure better outcomes for consumers.

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

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

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

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

The Assessment Team found the organisation has a range of policies and procedures to guide staff practice and processes were effective in relation to open disclosure. However, The Assessment Team was not satisfied the service demonstrated the organisation’s clinical governance framework was effective in relation to medication management, antimicrobial stewardship and minimising the use of restraint. The Assessment Team provided the following evidence relevant to my finding:

* Medication administration data and incidents is not monitored to identify trends and opportunities for improvement and ensure best practice care is being provided to consumers. This led to management having no awareness that ‘medication competent’ carers were administering as required medication without clinical supervision, which has resulted in consumers receiving as required medication on a regular and prolonged basis without comprehensive review of their needs.
* The service does not maintain a log of all infections and treatment utilised for consumers. There is no capture of information about the type of infection, antibiotics prescribed, organism located and confirmed by pathology, antibiotics or treatment and care intervention. There is no evidence the service trends and analyses infection rates each month and identifies opportunities for improvement.
* The service does not have a designated Infection prevention and control lead who has completed an identified infection prevention and control course.
* Three consumers were not identified as being subject to chemical and mechanical restraint, which resulted in staff being unaware of the correct monitoring and management to ensure it is used minimally.

The provider acknowledges some aspects of deficits identified by the Assessment Team, however, the provider’s response includes further information in relation to the use of restraint. The response states psychotropic medication is administered to two consumers to treat diagnosed conditions of insomnia and Alzheimer’s disease, including reducing risk of injury and promoting relaxation, and the use of a dignity suit has been agreed by one consumer to maintain their comfort and prevent certain behaviours.

The provider’s response includes evidence demonstrating action taken in response to deficits identified by the Assessment Team, including, implementation of a restrictive practices template, consideration of using an electronic incident reporting system, recruitment of additional staff to provide greater clinical oversight and updating medication policies procedures.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates that at the time of the Site Audit, the organisation’s clinical governance framework was not effective in relation to medication management, antimicrobial stewardship and minimising the use of restraint.

Clinical governance processes were not effective in identifying staff were not administering medication in line with best practice guidelines or organisational policy. As a result, consumers were administered as required medication on a regular and prolonged basis without clinical review to ensure medication was effective and in line with their clinical needs.

The service does not monitor and review infections to ensure they are being effectively managed and antibiotic use is appropriate. There is no evidence that infection rates are trended and analysed to monitor consumers’ changing condition, identify need for a Medical officer review or identify opportunities for improvement. Additionally, while the service has appointed an Infection prevention and control lead, they have not undertaken appropriate training to ensure they have the skills and knowledge to effectively implement and improve infection prevention and control practices within the service.

In relation to the use of chemical restraint, psychotropic medication administered to one consumer falls within the definition of chemical restraint as per the *Quality of Care Principles 2014*, as it was used to treat Alzheimer’s disease, which is not consistent with the medication’s approved use.

In relation to mechanical restraint, the use of a dignity suit in relation to one consumer falls within the definition of mechanical restraint as per the *Quality of Care Principles 2014,* as it was used to influence the consumer’s behaviour. While the provider asserts the consumer agreed to resume wearing the dignity suit to maintain their comfort, the discussions regarding re-introducing the restraint were prompted by a return of and aim to minimise the behaviour.

I have considered that the service was unable to demonstrate the use of restraint was minimised, as staff were unaware of correct monitoring and management processes.

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

# Areas for improvement

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

**Standard 2 Requirement (3)(a)**

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

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

* Ensure staff have the skills and knowledge to:
  + provide appropriate care relating to medications and continence;
  + ensure information relating to consumers’ personal and clinical care needs is documented and effectively communicated to others.
* Ensure policies, procedures and guidelines in relation to best practice care are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care.

**Standard 7 Requirement (3)(c)**

* Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.

**Standard 8 Requirements (3)(d) and (3)(e)**

* Review the organisation’s risk management processes in relation to managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to the use of restraint, medication administration and antimicrobial stewardship.