Performance

Report

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| Name of service: | Harold Williams Home |
| Service address: | 267 Eyre Street BROKEN HILL NSW 2880 |
| Commission ID: | 0027 |
| Approved provider: | Southern Cross Care (Broken Hill) Ltd |
| Activity type: | Site Audit |
| Activity date: | 14 February 2023 to 17 February 2023 |
| Performance report date: | 18 April 2023 |

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

**This performance report**

This performance report for Harold Williams Home (**the service**) has been prepared by K. Rochow, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with a sample of staff, consumers, representatives, management and others; and
* the provider’s response to the Assessment Team’s report received on 24 March 2023.

# Assessment summary

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

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

# Areas for improvement

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

**Standard 2 Ongoing assessment and planning with consumers:**

* **Requirement (3)(a):**
  + Ensure assessment and planning processes considers risks associated with consumers’ care, services and choices to engage in activities of their choosing.
* **Requirement (3)(b):**
  + Ensure assessment information is used to develop specific strategies to support consumers.
  + Ensure specialist information is used to inform the development of care plans.
* **Requirement (3)(e):**
  + Ensure review and reassessment processes are undertaken following incidents or when changes in consumers’ conditions, needs or preferences are identified.

**Standard 3 Personal care and clinical care:**

* **Requirement (3)(a):**
  + Ensure each consumer is provided with safe and effective clinical care, including wound care and management which is best practice and monitoring post falls.
* **Requirement (3)(b):**
  + Ensure consumers are provided with behaviour support which addresses their individual needs.
* **Requirement (3)(d):**
  + Ensure identified changes in consumers’ physical conditions are acted upon, including changes to wounds such a deterioration or infection.
* **Requirement (3)(f):**
  + Ensure consumers are referred to relevant health specialists or medical officers in accordance with medical officer requests and consumers’ clinical needs.

**Standard 4 Services and supports for daily living:**

* **Requirement (3)(a):**
  + Ensure each consumer gets safe and effective services and supports for daily living which meets consumers’ needs, goals and preferences and optimises their independence, health, well-being and quality of life, specifically for consumers living with dementia.
* **Requirement (3)(c):**
  + Ensure consumers are supported to participate in things of interest to them.
  + Ensure group and individual activity plans are developed based on consumers’ assessed needs and interests.

**Standard 6 Feedback and complaints:**

* **Requirement (3)(c):**
  + Ensure complaints are acknowledged, investigated and actioned, including discussion actions and outcomes with complainants.
  + Ensure complaints are logged to support effective monitoring of complaints progress and status, such as open or closed.
* **Requirement (3)(d):**
  + Ensure complaints are trended and analysed to identify opportunities for improvement.

**Standard 7 Human resources:**

* **Requirement (3)(a):**
  + Ensure staffing levels and mix are appropriate to support the safe and effective delivery of care, including to provide effective and safe wound care, and support responsive behaviours through individualised care and strategies.
* **Requirement (3)(c):**
  + Ensure staff are monitored and provided with support and training when deficits are identified.
  + Ensure monitoring processes establish staff competency and efficacy of practice, including clinical and lifestyle staff.

**Standard 8 Organisational governance:**

* **Requirement (3)(b):**
  + Ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery, including through awareness and action of identified risks and clinical and complaint trends.
* **Requirement (3)(c):**
  + Ensure effective organisation wide governance systems in relation to information management systems, continuous improvement, workforce governance and feedback and complaints, including ensuring monitoring processes are effective in monitoring staff practices and processes.
* **Requirement (3)(d):**
  + Ensure effective risk management systems and practices in relation managing high-impact or high-prevalence risks associated with the care of consumers or managing and preventing incidents, including monitoring clinical risks and acting upon each incident.
* **Requirement (3)(e):**
  + Ensure the service’s processes within the clinical governance framework and those responsible for monitoring clinical care, identify and monitor the actual delivery of care, to ensure it is both quality and safe care.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | 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. | Compliant |

Findings

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

The Assessment Team recommended Requirement (3)(d) in this Standard as not met. Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team and have found this Requirement to be compliant. I have provided reasons for my findings below.

**Requirement (3)(d)**

The Assessment Team found the service was unable to demonstrate that each consumer is supported to take risks to enable them to live the best life they can, specifically in relation to implementing and discussing risk mitigation strategies. The Assessment Team provided the following information and evidence relevant to my finding:

* While dignity of risk forms with risk mitigation strategies had been completed for six consumers in relation to risks associated with a variety of activities, for two consumer this had not occurred.
  + A consumer (Consumer C) had a mobility assessment completed which found they were no longer able to weight bear and required the use of a comfort chair. However, management confirmed no risk assessment was undertaken in relation to use of the comfort chair or consideration of safety measures when the consumer was using the chair.
    - The consumer has fallen twice from the comfort chair, however, risk assessment processes have not been undertaken to consider measures or strategies to ensure Consumer C’s safety.
    - Management confirmed no formal risk assessment was undertaken in relation to the suitability of the comfort chair following the two falls.
    - Staff confirmed they had not received specific instructions in relation to the Consumer C’s safety when using the comfort chair.
    - Consumer C’s representative said the consumer is impatient and expects immediate assistance when transferring from their chair to the bed. The representative said they were consulted about the risks and strategies in relation to the previous chair and were overall happy with the care provided.
  + A consumer (Consumer H) did not have a risk assessment completed in relation to an activity they are choosing to do. Management said they had not considered undertaking a risk assessment for this activity and were unaware of the details of the consumer’s engagement in this activity or any associated risks.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response includes that while the service is confident that each consumer is treated with dignity and respect, the provider recognises that workforce changes have impeded clinical risk identification for two consumers. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Risk assessments and care plans for Consumer C and Consumer H will be reviewed.
* Education to be provided to all staff in relation to risk identification and risk management.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

While I acknowledge that the provider has accepted the Assessment Team’s findings and have implemented or planned remedial actions in response to the deficiencies identified, I consider that the evidence and information relating to Consumer C and Consumer H more specifically relate to Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers. That is, the core deficit relates to the service not assessing relevant risks associated with Consumer C’s use of the comfort chair and Consumer H’s choice to participate in an activity of their choosing.

In coming to my finding, I consider that Consumer C had a change in their ability to mobilise, which made it necessary to change the chair they used when sitting out of bed. Therefore, the use of this new chair was a new requirement for the consumer and should have been assessed for associated risks through the service’s assessment and planning processes. The evidence does not indicate that Consumer C insisted they sit in this particular chair but appeared to be a chair provided to consumer to support them to sit out of bed during the day. As such, the evidence relates to the deficiencies in the service’s assessment and planning processes, rather than deficits in supporting the consumer to take risks to live their best life.

I have also considered that while Consumer H did not have a risk assessment in relation to an activity they are choosing to participate in, the Assessment Team’s report did not include specific evidence that staff are not supporting Consumer H to live the best life they can. Rather, the core deficits relate to the service’s assessment and planning processes, specifically considerations of risks associated with engagement in this activity, in Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

Additionally, I have considered other evidence in the Assessment Team’s report, specifically that the service demonstrated dignity of risk forms have been completed for six consumers in relation to risks associated with variety of activities with risk mitigation strategies identified.

For the reasons detailed above, I find Requirement (3)(d) in Standard 1 Consumer dignity and choice to be compliant.

**Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f)**

In relation to Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Consumers and representatives said staff treat consumers with dignity and respect, and the Assessment Team observed staff interacting with consumers in a kind and respectful manner. Management described processes used to understand consumers’ history, culture and diversity. Staff said they participate in diversity training and access information about consumers’ backgrounds in care planning documentation, with staff demonstrating familiarity with consumers’ stories.

Consumers said staff know them, what is important to them and how this influences their care. Consumers’ history and cultural background is obtained as part of the admission process and staff said they familiarise themselves with consumers through care documentation, conversations with consumers and representatives and were able to demonstrate awareness of consumers’ histories and culture.

Consumers said they are supported to exercise choice and independence, maintain relationships of meaning both inside and outside the service. Staff described how they support consumers to feel empowered and to be independent. Consumer choices were reflected in care planning documentation.

Most consumers and representatives said they are informed of what is occurring at the service via newsletters, care planning processes and verbal discussions with staff and management.

Consumers said their privacy is respected by staff and confidentiality is maintained when personal information is being discussed. Five consumers indicated that their privacy is interrupted by consumers who exhibit responsive behaviours of wandering, however, I have considered the core deficits in relation to this matter in Requirement (3)(b) in Standard 3 Personal care and clinical care. Staff practices indicated a respect of consumers’ privacy.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice to be compliant.

# Standard 2

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

Findings

This Quality Standard is assessed as non-compliant because three of the five specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements (3)(a), (3)(b), (3)(d) and (3)(e) as not met. Based on the Assessment Team’s report and the provider’s response, I have come the same view as the Assessment Team in relation to Requirements (3)(a), (3)(b) and (3)(e) and have found these Requirements to be non-compliant. However, in relation to Requirement (3)(d), I have come to a different view from the Assessment Team and have found this Requirement to be compliant. I have provided reasons for my findings below.

**Requirement (3)(a)**

The Assessment Team found the service was unable to demonstrate assessment and planning, including consideration of risks to consumers’ health and well-being, informs the delivery of safe and effective care. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer (Consumer A) did not have a pain assessment completed when the consumer complained of pain following a fall.
* A consumer’s (Consumer B) progress notes demonstrates the consumer had pain in various areas of their body but this is not reflected in the pain assessment chart. Clinical staff said the pain reassessment was incorrect as it indicated Consumer B does not have pain but the consumer does verbalise pain and is administered ‘as required’ pain medication and non-pharmacological strategies to address acute pain.
* Consumer B’s care plan identifies responsive behaviours, however, the behaviour assessment does not provide a history, assessment or strategies to guide staff.
* A consumer (Consumer C) has fallen twice from the comfort chair, however, risk assessment processes have not been undertaken to consider measures or strategies to ensure Consumer C’s safety, nor had allied health staff reviewed the consumer following these falls.
* A consumer’s (Consumer D) diabetic management plan is inconsistent with the medical officer’s directives.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* External clinical consultants will complete assessment and care plan reviews for all consumers.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate assessment and planning, including consideration of risks to consumers’ health and well-being, informs the delivery of safe and effective care and services.

In coming to my finding, I have relied upon the examples provided by the Assessment Team in this Requirement, relating to staff not completing pain assessments when a consumer presented with pain to identify pain associated with provision of care and services, the omission of history, assessment or strategies in Consumer B’s behaviour assessment when the care plan included description of several responsive behaviours, and inconsistencies in Consumer D’s diabetic management plan which did not support medical officer directives to manage a clinical condition.

I have also considered evidence presented in Requirement (3)(d) in Standard 1 Consumer dignity and choice in relation to Consumer C and H, which demonstrated the service’s assessment and planning processes did not consider risks associated with the use of a comfort chair for Consumer C when the chair was initially implemented or had fallen twice from the chair, or risks associated with Consumer H engaging in an activity of their choosing.

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

**Requirement (3)(b)**

The Assessment Team found the service was unable to demonstrate assessment and planning identifies consumers’ wishes and goals. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer (Consumer D) was reviewed by specialist dementia services, however, their recommendations were not all included in the consumer’s care plan.
* Consumer D’s care plan in relation to sleep does not include strategies for staff to support the consumer to settle overnight in context of the consumer exhibiting responsive behaviours of wandering overnight.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* The external advisor will conduct a further discovery activity to determine scope of works relating to care reassessment and care plan reviews.
* Training and mentoring plan has been developed to support clinical transactions and a clinical leadership approach to implementation of recommendations made by external professional services.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate assessment and planning identifies and addresses consumers’ current needs, goals and preferences. However, I acknowledge the Assessment Team provided evidence that the service has effective assessment and planning processes in relation to advance care planning and end of life planning if the consumer wishes.

In coming to my finding, I have relied upon the evidence associated with Consumer D in relation to care planning not considering recommendations by specialists to meet the consumer’s needs.

I have also considered evidence presented in Requirements (3)(a) and (3)(c) in Standard 4 Services and supports for daily living where lifestyle staff were unable to demonstrate for Consumer D and G how assessment information is used to develop specific strategies to support these consumers who are living with a cognitive impairment and who exhibit responsive behaviours of wandering. While assessment information identified these consumers’ specific interests, activities and connections, care plans did not include strategies to support the consumers to engage in these activities, interests or maintain connections.

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

**Requirement (3)(d)**

The Assessment Team found the service was unable to demonstrate 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. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer (Consumer B) indicated they did not feel like they had been informed about how serious their wound was and whether it would improve.
* One consumer said they did not know what a care plan was or that they could have a copy.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

While I acknowledge that the provider has accepted the Assessment Team’s findings and have implemented or planned remedial actions in response to the deficiencies identified, I consider that the evidence and information presented in relation to Consumer B are more specifically relevant to Requirements in Standard 3 Personal care and clinical care. That is, the core deficits in relation to Consumer B relates specifically to deficits in wound management processes, which I have addressed in Requirements (3)(b) and (3)(d) in that Standard.

While the Assessment Team spoke with one consumer who said they did not know what a care plan was or that they could have a copy, I have considered other evidence presented in this Requirement, including that two representatives said they are provided with a hard copy of the care plan and three staff confirmed they have access to consumers’ care plan.

On balance of the above evidence, I find that the service does has processes to ensure outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and service plan that is readily available to the consumer, and where care and services are provided. Additionally, the provider’s improvement actions will ensure consumers are aware they have and can access their care plan.

For the reasons detailed above, I find Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers to be compliant.

**Requirement (3)(e)**

The Assessment Team found the service was unable to demonstrate all consumer care plans are consistently reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals and preferences of the consumer. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer’s swallowing ability was not assessed by a speech pathologist following a decline in their swallowing ability.
* A consumer’s care needs and strategies in relation to managing falls were not reviewed for effectiveness following medical officer recommendations following several falls.
* A consumer (Consumer C) was not reviewed after having a fall from a comfort chair on two occasions.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* The external advisor will conduct a further discovery activity to determine scope of works relating to care reassessment and care plan reviews.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.
* Training and mentoring of clinical staff in relation clinical assessment and planning, monitoring clinical competency in accordance with professional standards.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate review of care and services when circumstances change or when incidents impact on the needs, goals and preferences of the consumer.

In coming to my finding, I have relied upon the examples provided by the Assessment Team in this Requirement, relating to staff not completing reviews of plans of care when there is a change in consumers’ conditions or following incidents. I consider that the evidence presented indicates that staff were aware of changed conditions but did not initiate review or reassessment processes to ensure care and services continued to meet consumers’ needs.

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

# Standard 3

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

Findings

This Quality Standard is assessed as non-compliant because four of the seven specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) as not met. Based on the Assessment Team’s report and the provider’s response, I have come the same view as the Assessment Team in relation to Requirements (3)(a), (3)(b), (3)(d) and (3)(f) and have found these Requirements to be non-compliant. However, in relation to Requirement (3)(e), I have come to a different view from the Assessment Team and have found this Requirement to be compliant. I have provided reasons for my findings below.

**Requirement (3)(a)**

The Assessment Team found the service was unable to demonstrate that each consumer gets safe and effective clinical care that is best practice, is tailored to their needs and optimises their health and well-being, specifically in relation to wound care and post falls management. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer’s (Consumer B) wounds were not effectively managed in accordance with best practice, tailored to their needs or optimised the consumer’s health and well-being. Specifically:
  + Wound documentation showed that Consumer B’s two wounds were not managed/dressed in accordance with the prescribed wound management plan (including frequency) and wound assessment information did not always include relevant information such as wound length, depth, width or stage. Wound documentation for both wounds indicates the wounds are deteriorating.
    - Clinical staff said Consumer B’s wounds cannot always be attended in accordance with the prescribed regime due to time constraints, including not having a registered nurse to review the wounds on a weekly basis.
    - Clinical staff acknowledged that wounds measurements are not always completed.
  + Progress notes showed Consumer B’s medical officer prescribed a topical cream for a wound/skin condition which was to be used after personal care twice per day. However, this cream was not ordered or was not available for at least three weeks.
* Two consumers did not have their neurological observations undertaken in accordance with the service’s falls management policy. Additionally, one consumer’s medical officer was not notified of an unwitnessed fall in accordance with the service’s policy.
* Consumer C’s progress notes shows the consumer has had several falls and the medical officer recommended specific safety equipment be used by the consumer. However, there is no evidence of this equipment being assessed or tailored to the consumer’s needs or suitability.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* External advisors have commenced onsite and will commence action on a holistic quality improvement plan.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate that each consumer gets safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being.

In coming to my finding, I have relied upon evidence from documentation and interviews with clinical staff that Consumer B’s wounds have not been managed in accordance with the prescribed regimes, including re-dressing the wounds in accordance with the prescribed frequency and documenting wound assessment information to support clinical staff to monitor and identify wound healing/deterioration and/or efficacy of the wound management regime. Additionally, Consumer B was not administered a prescribed topical cream for a skin/wound condition for three weeks.

I have also considered that staff did not manage consumers’ neurological observations post falls in accordance with the service’s policy to ensure optimal assessment and monitoring was provided.

Therefore, I find that the service was unable to demonstrate that each consumer was provided with safe and effective clinical care, with a significant amount of weight given to the staff’s failure to provide appropriate wound care, management and monitoring for Consumer B, including application of prescribed creams.

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

**Requirement (3)(b)**

The Assessment Team found the service was unable to demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer, specifically in relation to the management of a consumer’s responsive behaviour of wandering or risks associated with falls. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer’s (Consumer D) responsive behaviour of wandering has not been effectively managed and is significantly impacting on the safety and well-being of other consumers.
  + Five consumers said Consumer D’s responsive behaviour of wandering is impacting on their quality of life and safety. Additionally, complaints information showed five complaints from four consumers in relation to Consumer D’s responsive behaviours. However, the service was unable to demonstrate consumers’ complaints are effectively managed or resolved (see Requirement (3)(c) in Standard 6 Feedback and complaints).
  + Consumer D’s progress notes demonstrate a recent escalation of responsive behaviours of wandering, including being in other consumers’ rooms, attempting to pull them out of bed/physically interfering or laying on their beds. Additionally, prior to this escalation, Serious Incident Response Scheme (SIRS) reports show there were four incidents associated with Consumer D’s responsive behaviour of wandering.
  + All recommendations by specialist dementia support services have not been implemented to support effective management, including reducing monitoring blood glucose levels from twice daily to weekly and to use a picture of younger version of Consumer D or their partner on the consumer’s door to support Consumer D to identify their room.
  + Six care staff and two clinical staff confirmed Consumer D continually intrudes into other consumers’ rooms and is impacting them in various ways. Most indicated staffing levels impact their ability to redirect Consumer D and feel the responsive behaviour is not effectively managed.
  + Management was aware of Consumer D’s responsive behaviours of wandering.
* While Consumer C has had two falls from a chair, the consumer has not been reviewed by allied health to determine the suitability of the chair or what strategies staff should use when the consumer uses the chair to ensure their safety.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* External advisors have commenced onsite and will commence action on a holistic quality improvement plan.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer, specifically in relation to management of risks associated with responsive behaviours.

In coming to my finding, I have relied upon evidence from documentation and interviews with staff and consumers that Consumer D’s responsive behaviours of wandering have been ongoing for several months, impacting on consumers’ feelings of safety and well-being. While I acknowledge the service has sought assistance from specialist dementia support services, the service has not implemented and trialled all recommended strategies and current behavioural support strategies are not effective which results in Consumer D impacting other consumers. Additionally, management are aware of consumers’ concerns and incidents associated with Consumer D’s responsive behaviours but review of strategies or the implementation of effective behavioural support strategies has not occurred to ensure that risks to both Consumer D and other consumers are eliminated or minimised, including physical altercations. Therefore, I find that the service was unable to demonstrate effective management of high-impact or high-prevalence risks associated with the care of Consumer D.

In relation to Consumer C who has had two falls from a chair, the consumer has not been reviewed by allied health to determine the suitability of the chair or what strategies staff should use when the consumer uses the chair to ensure their safety. I considered this relevant to assessment and planning processes in Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, however, acknowledge that risks associated with the use of the chair after the first fall were not considered and therefore, risks associated with Consumer C’s falls management have not been identified or specific strategies implemented to minimise the risk of the reoccurrence of falls or injuries.

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

**Requirement (3)(d)**

The Assessment Team found the service was unable to demonstrate deterioration or changes in consumers’ cognitive function or physical condition is recognised and responded to in a timely manner. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer (Consumer B) has two wounds which staff had identified as having signs of deterioration and/or infection but did not demonstrate actions taken to respond these changes. Progress notes showed these wounds continued to deteriorate over several weeks when changes to the wounds were first identified.
  + Progress notes show that for one of Consumer B’s wound, it was observed by clinical staff to have deteriorated, with black, green exudate and possible infection, however, the wound was not escalated to the medical officer or wound care specialist. The wound continued to exhibit signs of deterioration and infection for approximately four weeks but staff have not responded to the change in the wound. At the time of the Site Audit, the wound had not been reviewed by the medical officer.
  + Progress notes show that for another of Consumer B’s wounds, it was deteriorating but staff did not take actions to address the change in the wound.
  + Consumer B said they were concerned about their wound and felt they were in holding pattern in relation to the wound and that staff were not proactive in relation to the wound. The consumer indicated they did not feel like they had been informed about how serious the wound was and whether it would improve. Additionally, the consumer indicated they had previously been to hospital for intravenous antibiotics which made the wound better. The consumer has requested that staff send them to hospital on several occasions but this has not occurred.
  + Clinical staff said they had not discussed the severity of the wounds with Consumer B and had not referred the consumer’s wounds to the medical officer or transfer to hospital even though they were aware the consumer’s wounds had deteriorated.
  + Clinical staff said they are aware that Consumer B’s wounds can often become saturated/wet but had not considered a strategy to manage the maintenance of the wound dressings.
* Progress notes for consumers C and D did not always capture when care was provided or refused, leading to challenges in confirming delivery of personal care.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* External advisors have been appointed to assist the service to comply with responsibilities in relation to care and services, including undertaking a complete review of care plans in relation to Consumers B, C and D.
* Undertake a review of handover communications across all shifts, between all departments within the service, including shift to management, management to Board level and identification of corrective actions.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate that deterioration or change of a consumer’s physical condition is recognised and responded to in a timely manner.

In coming to my finding, I have relied upon evidence specifically relating to Consumer B’s wounds. I consider progress notes and feedback from staff and Consumer B indicates staff identified Consumer B’s wounds to have deteriorated with potential infection over several weeks but did not respond these changes in the wound to minimise or prevent further deterioration or treat potential infection. Therefore, I find the service was unable to demonstrate they responded to a change in Consumer B’s physical condition of their wounds.

While the Assessment Team asserts that progress notes for Consumer C and Consumer D did not always capture when care was provided or refused, this relates more specifically to the provision of personal and clinical, and associated deficits for these consumers have been considered in Requirement (3)(a) and Requirement (3)(b) in this Standard.

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

**Requirement (3)(e)**

The Assessment Team found the service was unable to demonstrate information about consumers’ conditions, needs and preferences are documented, communicated within the organisation and with others where responsibility for care is shared. The Assessment Team provided the following information and evidence relevant to my finding:

* In relation to Consumer D, recommendations by specialist dementia support services were not communicated to lifestyle staff, resulting in one recommended strategy not being implemented.
* While staff identified changes to Consumer B’s physical condition and queried an infection, this was not used to notify the relevant allied health professional.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* The external advisor will conduct a further discovery activity to determine scope of works relating to care reassessment and care plan reviews.
* All areas will be added to the plan for continuous improvement for monitoring across the entire consumer cohort.

While I acknowledge that the provider has accepted the Assessment Team’s findings and have implemented or planned remedial actions in response to the deficiencies identified, I consider that the evidence and information presented in this Requirement are more specifically relevant to other Requirements in this Standard. That is, the core deficits in relation to Consumer D relates specifically to deficits in managing the risks associated with the consumer’s responsive behaviours because staff were aware of the specialist strategies but did not action implementation to support effective management. Additionally, in relation to Consumer B, the core deficit relates to the service’s referrals processes and appropriately responding to a change in physical condition rather than communication because staff were aware of the of change to Consumer B’s physical condition but did not refer them to the relevant allied health professional or review/change the provision of care to meeting the changed needs.

In coming to my finding, I have also considered other evidence presented by the Assessment Team in this Requirement, including that the service could demonstrate how clinical staff communicate and update care staff through handover processes, through both verbally and written communications. Additionally, clinical staff said they discuss consumers’ care and incidents at the weekly clinical meeting.

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

**Requirement (3)(f)**

The Assessment Team found the service was unable to demonstrate that consumers are referred to health care specialists or medical officers when required or in a timely manner. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer’s (Consumer D) medical officer recommended the consumer be referred to three separate specialist health service providers. However, staff only made one referral and omitted to refer the consumer to the two other health specialist services as requested by the medical officer.
* A weight chart for a consumer demonstrated they had lost an amount of weight which, according to the service’s policy, should have resulted in a referral to a dietitian. However, this referral was not made and clinical staff acknowledged the referral had not been made.
* A consumer had an incident associated with choking and while clinical staff assessed the consumer’s dietary needs, they did not refer the consumer to a speech pathologist.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* The external advisors will conduct a full investigation into the Assessment Team’s findings.
* Act in partnership the clinical nurse consultant to ensure timely and appropriate referrals are made for consumers who require them.
* Education to be provided on clinical transactional leadership related to implementing and monitoring referral processes.
* Examples provided within the report will be added to the plan for continuous improvement for monitoring and measuring of improved consumer outcomes, including the consumers identified by the Assessment Team.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate that consumers are referred to medical officers and other health specialists in accordance with their needs.

In coming to my finding, I have relied on evidence for three consumers in this Requirement which demonstrates staff did not refer consumers to relevant health professionals in accordance with their needs.

I have also considered findings and evidence in relation to Consumer B in Requirement (3)(d) in this Standard, which demonstrates staff also did not refer the consumer to specialists or medical officer in relation to identified deterioration and potential infection of wounds.

I have also considered evidence from Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, in relation to Consumer C, who was not referred to allied health specialists following two falls from a comfort chair.

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

**Requirement (3)(g)**

In relation to Requirement (3)(g) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Staff confirmed they have participated in infection control training, including using personal protective equipment. The organisation has an Infection Prevention and Control lead to monitor staff training and competency. The service has an outbreak management plan. The Assessment Team observed staff using personal protective equipment and cleaning shared equipment between uses.

Monthly reporting confirms pathology is collected prior to the prescription and administration of antimicrobial use, with infection recorded and reported.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirement (3)(g) in Standard 3 Personal care and clinical care to be compliant.

# Standard 4

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

Findings

This Quality Standard is assessed as non-compliant because two of the seven specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements (3)(a) and (3)(c) as not met. Based on the Assessment Team’s report and the provider’s response, I have come the same view as the Assessment Team and have found these Requirements to be non-compliant. I have provided reasons for my findings below.

**Requirement (3)(a)**

The Assessment Team found the service was unable to demonstrate that each consumer gets safe and effective services and supports for daily living that meet consumers’ needs, goals and preferences, and optimises their independence, health, well-being and quality of life. The Assessment Team provided the following information and evidence relevant to my finding:

* Lifestyle staff were unable to demonstrate how assessment information is used to develop specific strategies to support two consumers living with a cognitive impairment and who exhibit responsive behaviours of wandering. Specifically:
  + A consumer’s (Consumer G) lifestyle and leisure form identifies specific interests, activities and connections but does not include specific strategies to support Consumer G’s engagement in these identified interests, activities or connections. Staff were unable to describe how they support Consumer G to engage in the identified interests and indicated Consumer G chooses from the activities offered. Additionally, activities recorded on Consumer G’s lifestyle chart does not record level of enjoyment from activities attended.
  + A consumer’s (Consumer D) lifestyle and leisure form identifies specific interests, activities and supports for daily living, however, specific strategies have not been planned to guide staff in supporting Consumer D.
* Several consumers are not satisfied consumers living with dementia and who exhibit responsive behaviours of wandering are effectively supported or engaged which impacts on their well-being or quality of life.
* Lifestyle staff said there are not activities tailored to meet the needs, goals and preferences for consumers living with dementia, such as Consumer D. Additionally, a specific ‘dementia support shift’ is rostered but often not filled and often when it is filled, the staff member is used to perform care duties rather than engagement with consumers living with dementia.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* External advisors have commenced onsite and will conduct a full investigation into the Assessment Team’s report findings.
* Examples provided within the report will be actioned with targeted reassessment, care plan review, training and mentoring of lifestyle staff.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate that each consumer gets safe and effective services and supports for daily living which meets consumers’ needs, goals and preferences and optimises their independence, health, well-being and quality of life. This finding is specifically in relation to two consumers who are living with dementia.

In coming to my finding, I have relied upon documentation and that staff did not demonstrate that Consumer D and Consumer G had specific strategies of services and supports to assist them in engaging in interests, activities and connections to support the optimising of their independence, health, well-being and quality of life. While the assessment process had identified specific needs, goals and preferences of these consumers, specific strategies had not been identified and consumers and staff interviewed indicated these consumers have unsupported responsive behaviours of wandering which is impacting other consumers. Additionally, the specific ‘dementia support shift’ is often not filled or used to undertake care duties, missing an opportunity for staff to meaningfully engage with these consumers. Therefore, I find that the service was unable to demonstrate Consumer G and Consumer D are meaningfully engaged to meet their needs, goals and preferences to optimise their independence, health, well-being and quality of life.

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

**Requirement (3)(c)**

The Assessment Team found the service was able to demonstrate that each consumer gets services and supports for daily living to participate in the community and have social and personal relationships but was unable to demonstrate that each consumer can do things of interest to them. The Assessment Team provided the following information and evidence relevant to my finding:

* Lifestyle staff were unable to demonstrate how the activities plan is developed to be inclusive of consumers’ assessed interests and likes. Specifically, they were unable to demonstrate how information collected about consumers’ interests is used to develop activities at either an individual or group level.
* Lifestyle staff indicated in previous times, staff had attempted to support consumers living with dementia to do group activities but there was no specific activity plan. In relation to consumers living with dementia and who exhibit responsive behaviours of wandering, lifestyle staff were unable to demonstrate how they support two consumers, Consumer D and Consumer G, to be engaged in activities of interest to them as outlined in their assessments.
  + Activities records for these consumers do not record their level of enjoyment and while lifestyle staff said feedback in relation to activities is obtained from monthly consumer surveys and meetings, there is no planned approach to cater for individual consumer cohorts, including consumers living with dementia.
* The service’s policy directs that the activities program is to be scheduled over seven days, however, lifestyle staff are currently rostered over five days and there is no scheduled activities program on the weekend.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. However, the provider wishes to highlight that the Assessment Team included evidence in this Requirement in relation to three consumers which demonstrates that they are supported to do things of interest to them. Notwithstanding, the provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Undertake a full review of leisure and lifestyle interests, ‘About Me’ assessment, consumer feedback, meeting minutes and planning to meet person centred activities.
* Add to the plan for continuous improvement monitoring and measurement of improved consumer outcomes, specifically relating to Consumer D and Consumer G.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified and the positive examples in the Assessment Team’s report of three consumers being supported to engage in activities of interest them. Additionally, I acknowledge that the service was able to demonstrate that each consumer gets services and supports for daily living to participate in the community and have social and personal relationships. However, I find the service did not demonstrate that each consumer gets services and supports for daily living to assist them to do things of interest to them.

In coming to my finding, I have relied upon evidence that lifestyle staff were unable to demonstrate how activities are planned and developed to be inclusive of consumers’ assessed interests and likes at either an individual or group level. While there were examples of how individual consumers are supported to engage in things of interest to them, for Consumer G and Consumer D, the service was unable to demonstrate that they participate in their assessed activities of interest. Their activity records indicate the consumers have not been supported to engage in activities of interest to them. Additionally, I have considered that group activities are not developed based on consumers’ assessed needs or interests but are rather offered to consumers and they may choose to attend or not based on their level of interest. Additionally, the service was unable to demonstrate how they evaluate and monitor individual consumers’ engagement and enjoyment of activities. Therefore, I find that the service was unable to demonstrate that each consumer is provided with services and supports for daily living to do things of interest to them.

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

**Requirements (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g)**

In relation to Requirements (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Two consumers confirmed they are supported in their spiritual well-being by regular attendance at church services, with regular various denominations providing regular services onsite and a pastoral care coordinator providing one-to-one visits to support spiritual and social well-being. Care staff described how they support consumers’ psychological well-being, and the Assessment Team observed volunteers provided consumers with one-to-one support.

Overall, consumers and representatives said staff have knowledge of their needs and care is delivered in accordance with these preferences. Staff described mechanisms for how information is communicated with them about consumers’ care and how changes are also communicated within the service. The Assessment Team observed staff participating in handover processes.

Management described referral processes but acknowledged referrals are not always followed-up by staff in a timely manner due to time constraints. However, provided examples of individuals, other organisations and providers of other care and service who consumers have been referred to support their daily supports.

Overall, consumers and representatives were satisfied with meals provided, stating meals were of suitable quality and quantity, with alternatives to meals available. Care and kitchen staff were knowledgeable about consumer meal preferences and dietary requirements.

Consumers are satisfied with the equipment provided and said it was safe and well maintained. Maintenance and cleaning staff described processes they use to ensure equipment is safe, suitable, clean and well maintained.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living to be 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. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Quality Standard is assessed a compliant as all three specific Requirements have been assessed as compliant.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 5 Organisation’s service environment as met. The Assessment Team found the service environment is welcoming and promotes a sense of community and belonging, with effective systems and processes for maintaining a safe and clean service environment, including suitable furniture, fittings and equipment.

The Assessment Team provided the following information and evidence relevant to my finding:

The Assessment Team observed consumers, representatives and visitors utilising outdoor areas during the Site Audit. They also found the service environment to be welcoming, free from clutter and consumers’ rooms were personalised. Welcome signs are used to provide identification and orientation and handrails are installed in corridors to provide consumers with independence.

Consumers said the environment is safe, clean and well maintained. They also indicated maintenance staff attend to their requests in a prompt manner. Maintenance staff described processes and programs used to identify and manage maintenance or hazard issues and attend to routine and reactive maintenance tasks, using both internal staff and contractors to attend to these matters. Cleaning staff described their roles in maintaining the cleanliness of the service environment. The Assessment Team observed consumer rooms, communal areas and outdoor garden areas to be clean, tidy and well maintained.

Maintenance and cleaning staff described processes they undertake to ensure furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. The Assessment Team observed furniture, carpet and fittings to be clean and well maintained.

Based on the Assessment Team’s report, including the evidence and information above, I find all Requirements in Standard 5 Organisation’s service environment to be compliant.

# Standard 6

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

Findings

This Quality Standard is assessed as non-compliant because two of the four specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements (3)(c) and (3)(d) as not met. Based on the Assessment Team’s report and the provider’s response, I have come the same view as the Assessment Team and have found these Requirements to be non-compliant. I have provided reasons for my findings below.

**Requirement (3)(c)**

The Assessment Team found the service was unable to demonstrate appropriate action is taken in response to feedback and complaints. The Assessment Team provided the following information and evidence relevant to my finding:

* Three consumers indicated they are not satisfied that their complaints had not resulted in appropriate action, resolution or improvements.
* The service’s feedback log includes feedback and complaints submitted by consumers and representatives, however, it does not include actions taken in response to feedback and complaints.
  + The Assessment Team reviewed three months of feedback data which did not have follow-up actions or actions items for any of the logged feedback. The log also did not indicate which items had been rectified or which were ongoing.
* Management stated they do not monitor if complaints are actioned or required follow-up and were unable to identify which complaints on the log were rectified or required ongoing actions.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Findings within the Assessment Team’s report will be investigated with corrective actions including complaint trend analysis, complaint investigation and response, open disclosure conversations and complaint resolution.
* Planned training for management and staff in relation to feedback and complaints and open disclosure.
* Engaged an external advisor to provide support, including complaint management training.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. I also acknowledge that the Assessment Team found that staff were able to demonstrate understanding of open disclosure and management were able to provide recent examples of open disclosure. Additionally, consumers and representatives indicated staff are forthcoming when things go wrong and provide appropriate apologies and explanations in response to incidents. However, I find the service did not demonstrate that appropriate action is taken in response to complaints.

In coming to my finding, I have relied upon evidence that management are not actively monitoring the status of complaints, including if actions have been taken to remedy complaints or if complaints have been satisfactorily actioned. Additionally, the service’s feedback log did not demonstrate actions taken in response to complaints. I have also considered that three consumers who have submitted complaints are not satisfied their complaints have been remedied or resulted in improvements. Therefore, I find that the service was unable to demonstrate that appropriate action is taken in response to complaints.

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

**Requirement (3)(d)**

The Assessment Team found the service was unable to demonstrate that feedback is used to improve care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* Management was unable to provide examples of how feedback and complaints are used to improve care and services.
* Management have been unable to trend and analyse feedback and complaints since April 2022 because of a change in the electronic management system.
* While management were aware of complaints relating to a consumer who wanders and disturbs other consumers, they said a solution had not yet been found in response to the associated complaints.
* The service’s plan for continuous improvement (PCI) was not reflective of feedback provided and items on the PCI did not reflect actions or completion dates.
  + The Assessment Team identified two trends in complaints associated with managing responsive behaviours and food which were not included on the PCI.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Planned training and mentoring for key personnel in relation to improving quality of care and clinical governance, complaint analysis of trends and complaints management.
* Engaged an external advisor to provide support, including complaint management training.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services.

In coming to my finding, I have relied upon evidence that management were unable to demonstrate how feedback and complaints are used to improve care and services, including that trending and analysis of complaints has not been undertaken for approximately 10 months. While I acknowledge that management were aware of trend of complaints associated with responsive behavioural support, they were unable to demonstrate actions and improvements directly in response to several complaints associated with the same issue. Additionally, the service’s PCI did not include items associated with complaints trends to ensure actions were considered and implemented to improve care and services.

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

**Requirements (3)(a) and (3)(b)**

In relation to Requirements (3)(a) and (3)(b) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Consumer and representatives were aware of mechanisms available to make complaints and provide feedback and felt supported by management to provide feedback. Staff could describe the organisation’s complaints procedure and how they assist consumers to make complaints and manage verbal feedback. The Assessment Team observed feedback forms throughout the service and the feedback log had complaints logged from several sources.

Consumers and representatives are aware of external agencies who could assist them in raising concerns, and this information was also displayed throughout the service, including information regarding advocacy services. Consumers are also provided with information in relation to translation and advocacy services in the ‘welcome pack’ on entry to the service.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints to be compliant.

# Standard 7

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

Findings

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

The Assessment Team recommended Requirements (3)(a) and (3)(c) as not met. Based on the Assessment Team’s report and the provider’s response, I have come the same view as the Assessment Team and have found these Requirements to be non-compliant. I have provided reasons for my findings below.

**Requirement (3)(a)**

The Assessment Team found the service was unable to demonstrate the workforce is planned with an appropriate mix and number of staff to enable the delivery of safe and effective care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* Four consumers indicated they felt there was a lack of staff to assist in supporting the responsive behaviours of other consumers.
  + Management said they implemented a ‘dementia support shift’ to assist with supporting consumers’ responsive behaviours, however, this shift was not filled on nine of 15 days prior to the Site Audit.
  + Thee care staff and two clinical staff said they often don’t get their tasks completed due to supporting consumers’ responsive behaviours.
* Four consumers/representatives indicated there are insufficient staff and they often wait for extended periods when they use their call bell.
* Call bell response time data for a one-month period showed a significant number of call bells to be not answered in the ranges from ten minutes to over one hour. Management is not using call bell data to monitor staffing levels, mix or to trend and analyse.
* Allocations sheets showed in the two weeks prior to the Site Audit, there were 24 required shifts which had not been filled.
* Staff interviewed said unfilled shifts impacts on their ability to complete all their tasks and provide consumers with emotional support and clinical staff said they cannot always complete wound care due to time constraints.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Pausing new consumers entering the home to realign workforce availability to consumer numbers with the view to reassess once workforce management risks are contained.
* Undertake a risk assessment (call bell time in motion study) of shift allocation and identify consumers at risk and instigate strategies to ensure the maintenance of consumers’ safety and well-being.
* Undertake consumer consultation processes, including open disclosure meetings, regular consumer satisfaction surveys to measure improvements made to workforce allocations and call bell response times.
* External advisors will provide support with roster review, recruitment and selection of workforce, training and mentoring.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified, including pausing new consumers entering the service until workforce availability and risks have been identified. However, I find the service did not demonstrate that the workforce is planned to enable, and the number of workforce enables, the delivery and management of safe and quality care and services.

In coming to my finding, I have relied upon feedback from consumers and staff who indicate that staffing levels are directing impacting the provision of care and services, specifically that there is not enough time for staff to complete their tasks, including wound care, and that consumers are being impacted by the responsive behaviours of other consumers. I have also considered that management are not monitoring the outcomes of staffing levels, with call bell response times not monitored or investigated and that unfilled shifts are continuing to occur daily.

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

**Requirement (3)(c)**

The Assessment Team found the service was unable to demonstrate that the workforce is competent and has the knowledge to effectively perform their roles, specifically in relation to wound care, identification of wound deterioration and behaviour support. The Assessment Team provided the following information and evidence relevant to my finding:

* In October 2022, management identified a deficit in wound care and documentation, however, this did not result in training or monitoring of staff in relation to this aspect of clinical care. During the Site Audit, the Assessment Team identified that while staff had identified that Consumer B’s wound was showing signs of infection or deterioration, this was not reassessed or escalated for review. Additionally, staff were not completing wound care in accordance with the wound management plan or completing wound documentation correctly or completely to support effective wound management.
  + Management said wound charting had been discussed with clinical staff at the October 2022 registered nurse/enrolled nurse meeting but acknowledged staff were completing Consumer B’s wound charts incorrectly.
  + Management said Consumer B had not been referred to the medical officer for deterioration or suspected infection of their wounds because the medical officer was on leave and believed the hospital wound not accept Consumer B to just prescribe antibiotics.
* Consumer D, who has had ongoing/increasing responsive behaviours of wandering does not have a behaviour support plan which provides for specific behaviours, triggers or strategies. Consumer and staff interviews and documentation demonstrates Consumer D’s responsive behaviours are impacting on the safety and well-being of other consumers.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* The external advisors have commenced work onsite to provide clinical support and reassessment and care planning strategies for Consumer B and Consumer D.
* The external advisors will facilitate workforce training, including a 12-week mandatory education and training plan for all staff.
* Examples provided within the Assessment Team’s report will be added to the plan for continuous improvement and measurement of improved consumer outcomes, including; consumer and representative satisfaction surveys in relation to safe and effective care and clinical outcomes to measure improvement at regular interviews; review competency package used within the service against best practice guidelines in relation to behavioural management, monitoring and detecting wound deterioration and managing referrals; review competency assessment program frequency, currency and accuracy, including annual competency assessments.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified. However, I find the service did not demonstrate that the workforce is competent or has the knowledge in all relevant aspects of clinical care to effectively perform their roles.

In coming to my finding, I have relied upon the clinical management of both Consumer B and Consumer D, which demonstrates staff have not provided effective clinical care or decision making in relation to wound care/management or responsive behavioural management. While staff had identified potential wound infection and deterioration for Consumer B, there was no review/reassessment of the wound management plan, nor referral to the medical officer or relevant health specialist. Consumer B’s wound continued to show signs of deterioration over several weeks, however, clinical staff did not act upon these signs and symptoms. Additionally, staff did not develop a behaviour support plan for Consumer D to support the consumer’s responsive behaviours, even though staff were aware of the impacts on other consumers. Therefore, I find that staff have not demonstrated they are competent or have the knowledge to effectively manage wounds or support responsive behaviours.

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

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

In relation to Requirements (3)(b), (3)(d) and (3)(e) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Consumer and representatives felt staff interactions are kind and respectful and that staff know consumers well. The Assessment Team observed interactions between staff and consumers to be kind, respectful and patient. They were also observed to know consumers well and were caring when interacting with them.

Consumers and representatives felt confident in staff’s ability to deliver consumers’ care and that staff were knowledgeable. The Assessment Team found the service has effective recruitment and selection process. The Assessment Team also viewed training records for mandatory training and other training which showed all staff were up to date with this training.

Staff interviewed confirmed they participate in regular performance reviews and the performance appraisal log showed all staff are up to date with their performance reviews. Management said they monitor staff performance through peer feedback, complaint data and audits, and provided an example of performance management processes used for a staff member who had displayed unsatisfactory conduct at work.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(b), (3)(d) and (3)(e) in Standard 7 Human resources to be 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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

This Quality Standard is assessed as non-compliant because four of the five specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements (3)(b), (3)(c), (3)(d) and (3)(e) as not met. Based on the Assessment Team’s report and the provider’s response, I have come the same view as the Assessment Team and have found these Requirements to be non-compliant. I have provided reasons for my findings below.

**Requirement (3)(b)**

The Assessment Team found 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. The Assessment Team provided the following information and evidence relevant to my finding:

* Minutes and reports from monthly meetings were provided to demonstrate how the governing body has oversight, however, reports from these meetings did not include all high risks or clinical trends. Additionally, deficits identified in October 2022 in relation to wound care and management were not raised with the governing body, with wound care being identified as a deficit by the Assessment Team.
* The governing body receives numerical data relating to clinical and complaint trends but it did not receive information relating to analysis and trending of this information.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The provider’s response also included meeting minutes for an extraordinary executive management meeting, Special Board meeting and more recent Board meeting which demonstrates the commitment of management and the Board to recognise shortfalls and a strong commitment to restore the service to full compliance in partnership with the external advisors. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Commit to include examples provided within the report in the plan for continuous improvement for monitoring and assessment of improved overall consumer outcomes.
* Review Board reports, including presentation and agenda items to ensure it is in accordance with governance best practice guidelines and to include complaint and clinical indicator trend analysis.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified, including the demonstrated commitment to returning the service to full compliance. However, I find the service did not demonstrate that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services is accountable for their delivery.

In coming to my finding, I have relied upon evidence which indicates trends and deficits relating to wound care and behaviour support were evident but the Board was not aware to support the delivery of quality care and services. I have also considered that the Board, while provided with numerical data in relation to clinical and complaint trends, did not demonstrate they actively understand this data to ensure accountability for care and service delivery and improvement.

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

**Requirement (3)(c)**

The Assessment Team found the service was unable to demonstrate governance wide systems in relation to information management, continuous improvement, feedback and complaints, and workforce governance. However, the Assessment Team found the service were able to demonstrate governance wide systems in relation to financial governance and regulatory compliance. The Assessment Team provided the following information and evidence relevant to my finding:

**Information management:**

* The service was unable to demonstrate information management systems and processes were effective in providing and equipping staff with necessary information to enable them to perform their roles and analyse and mitigate risk.
  + Meeting minutes and reports did not always include information such as evaluation of data, interventions and actions taken in response to incidents, and incident logs did not always include risk mitigation strategies or past incident review or assessment.
  + Consumer G and Consumer D’s care plans did not provide staff with strategies to support the delivery of care.

**Continuous improvement:**

* While the service has a plan for continuous improvement, they were unable to demonstrate improvements from a range of sources such as feedback/complaints sand incidents.
* The plan for continuous improvement did not have action or completion dates, desired outcomes/goals. Additionally, it was unclear what actions has been undertaken and did not always identify a responsible persons.

**Workforce governance:**

* The service was unable to fill a significant number of unfilled shifts which impacted on the delivery of care and services. Additionally, there were previously identified deficits in staff knowledge and clinical practice which were not addressed or monitored and as a result these practices were identified by the Assessment Team.

**Feedback and complaints:**

* Management have not been using complaints/feedback to identify opportunities for improvements and they were unable to demonstrate how the complaints/feedback data is used to improve care and services.
* While feedback and complaints are logged, the log did not indicate if feedback was addressed or what steps were taken to rectify the complaints.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Commit to include examples provided within the report in the plan for continuous improvement for monitoring and assessment of improved overall consumer outcomes.
* Continuous improvement processes to include identification of improvements, clear action items, delegated person/role responsible to manage and measurable outcome training specific for key personnel.
* Plan for continuous improvement redevelopment and mentoring of the management team.
* Review of workforce governance processes and mechanisms to identify opportunities for improvement.
* Review complaints management mechanism to include data analysis and identification of improvements.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified, including the demonstrated commitment to returning the service to full compliance. While the service was able to demonstrate effective organisation wide governance systems in relation to financial governance and regulatory compliance, I find the service did not demonstrate effective organisation wide governance systems in relation to information management systems, continuous improvement, workforce governance and feedback and complaints.

In coming to my finding in relation to information management, I have relied upon evidence in Standard 2 Ongoing assessment and planning with consumers, Standard 3 Personal care and clinical care and Standard 4 Services and supports for daily living which indicates staff are not supported to deliver care and services using an accurate and up-to-date care plan for all consumers. I consider the several system and process deficits relating to care plans indicates the service’s information management governance systems have not been effective.

In coming to my finding in relation to continuous improvement, I have considered evidence in the Assessment Team’s report which demonstrates the service has not taken a planned approach to continuous improvement, including identifying key measurable goals, responsible persons and outcomes/actions. Additionally, the service was unable to demonstrate that key indicator data is used to identify improvement opportunities. Therefore, governance processes in relation to continuous improvement have not been effective.

In coming to my finding in relation to workforce governance, I have considered that the service has had a significant number of unfilled shifts impacting on the provision of care and services across these Standards and a known deficit in staff’s clinical practice and care was not addressed and monitored, indicating that governance systems relating to the workforce is not effective.

In coming to my finding in relation to feedback and complaints, I have considered that the service is not actioning individual complaints/feedback nor identifying trends or opportunities for improvement indicating that governance systems have not been effective in identifying these systemic deficits.

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

**Requirement (3)(d)**

The Assessment Team found the service was unable to demonstrate effective risk management systems and practices in relation to management of high-impact or high-prevalence risks associated with the care of consumers, managing and preventing incidents or supporting consumers to live their best lives. However, the Assessment Team found the service were able to demonstrate effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers. The Assessment Team provided the following information and evidence relevant to my finding:

* Monthly meetings and reports did not recognise Consumer B’s deteriorating wounds.
* Clinical governance meetings did not identify that Consumer C had two falls from a comfort chair and there was no reassessment or consideration of risks associated with the continued use of the chair.
* Clinical governance meetings and resident care committee meetings did not identify the ongoing and escalating responsive behaviours of Consumer D for several weeks, which resulted in failure to implement effective behavioural support strategies.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Commit to include examples provided within the report in the plan for continuous improvement for monitoring and assessment of improved overall consumer outcomes.
* Review care plans for risk assessments for Consumer B, C, D and H.
* Review high-impact and high-prevalence risks monitoring mechanisms for best practice management, risk assessment register, risk trend reporting and linking to the improvement plan.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified, including the demonstrated commitment to returning the service to full compliance. However, I find the service did not demonstrate effective risk management systems and practices in relation managing high-impact or high-prevalence risks associated with the care of consumers or managing and preventing incidents.

In coming to my finding, I have relied upon evidence which indicates consumers’ high-impact or high-prevalence risks have not been effectively managed for several weeks, indicating the service’s monitoring processes are not effectively identifying and managing these risks. I have also considered that the service is not using incidents to consider and implement strategies to minimise or prevent further incidents from occurring which is impacting on the provision of safe and effective care. Therefore, I find the service was unable to demonstrate effective risk management systems in relation to managing high-impact or high-prevalence risks associated with care and managing and preventing incidents.

In relation to supporting consumers to live their best life, I have considered the deficits associated with the risk assessment processes are directly related to Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers. Please see this Requirement for further reasoning. Therefore, I consider the service has effective risk management systems in relation to supporting consumers to live their best life.

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

**Requirement (3)(e)**

The Assessment Team found the service was unable to demonstrate effective clinical governance in relation to wound management, behaviour support and assessment and care planning processes. However, the Assessment Team found the service was able to demonstrate an effective clinical governance framework in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure. The Assessment Team provided the following information and evidence relevant to my finding:

* The service uses monthly resident care committees, daily handovers, resident of the day and monthly management reports to identify, assess, mitigate, manage and monitor risks. However, these process did not identify risks associated with the care of Consumer B and Consumer D who have both presented with ongoing clinical risks.
  + Clinical staff recognised deterioration and changes to Consumer B’s wounds but there was no follow-up, escalation or mitigation of risk associated with wounds.
  + Consumer D has had ongoing responsive behaviours which have not been effectively supported to prevent risk to the consumer and other consumers living at the service.
* While the service is identifying incidents, these are not being used to identify trends, drive continuous improvement, improve quality of care and services and to prevent similar incidents from occurring.
  + Three incidents in relation to Consumer D showed there were no mitigation strategies implemented to prevent reoccurrence or additional training or support provided to staff in relation to these incidents.
* The resident care committee identified an increase in falls but no strategies were identified to reduce the risk of falls, including for individual consumers.
* Consumer C and Consumer H did not have risk assessment completed for all risks activities.

The provider submitted a response to the Assessment Team’s report and have accepted the Assessment Team’s findings. The response provides assurances that immediate actions have been taken in response to the Assessment Team’s findings, including the commencement of a targeted and responsive action plan and training plan to remediate the identified deficiencies. Remedial actions initiated or planned include, but are not limited to:

* Commit to include examples provided within the report in the plan for continuous improvement for monitoring and assessment of improved overall consumer outcomes.
* Review clinical governance structures and processes to identify falls, wounds, behaviour risks to ensure clinical incident reporting, data trend analysis leads to identification of improvement.
* Review and analyse the resident care committee meeting agenda against the Quality Care Advisory Body Reform requirements.
* Provide mentoring support to key personnel and frontline registered staff on observing a clinical governance framework to identify and implement strategies to manage clinical risks and minimise impact on other consumers.

I acknowledge the provider’s response, including the planned remedial actions in response to the deficiencies identified, including the demonstrated commitment to returning the service to full compliance. However, I find the service did not demonstrate an effective clinical governance framework.

In coming to my finding, while I acknowledge the service could demonstrate an effective clinical governance framework in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure, I consider the service could not demonstrate that the clinical governance framework supported the delivery of safe and quality clinical care or opportunities for improvement. The service’s processes within the clinical governance framework and those responsible for monitoring clinical care did not identify that consumers were not receiving quality or safe care, in relation to actual clinical care delivery and assessment and care planning processes.

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

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