Heritage Botany

Performance Report

31-33 Edgehill Avenue
BOTANY NSW 2019
Phone number: 02 9316 9544

**Commission ID:** 0519

**Provider name:** Heritage Care Pty Ltd

**Site Audit date:** 29 March 2022 to 4 April 2022

**Date of Performance Report:** 20 May 2022

# Performance report prepared by

Samantha Hicks, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment conducted 29 March to 4 April 2022, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 4 May 2022.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

The Assessment Team interviewed consumers and representatives who mostly confirmed they can maintain their identity and live the life they choose, with their personal privacy respected. Consumers also advised that they are being supported to maintain connections with others and relationships of choice.

The Assessment Team however received some feedback from consumers/representatives, that they did not feel that their needs were being met and the staff do not treat them with dignity and respect. Some consumers and representatives said they didn’t consider they were culturally respected and raised concerns about communication systems for consumers who have communication difficulties. In addition, consumers/representatives provided feedback that showed consultations and inclusion in decision-making is not consistently occurring.

The Assessment Team also observed that consumers’ personal information was not protected due to poor staff practice.

The Quality Standard is assessed as Non-compliant as three of the six specific requirements have been assessed as Non-compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

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

The Assessment Team found that although some consumers feel that they are treated with respect and dignity there were some consumers who did not consider that they are treated with dignity and respect, and have their identity, culture and diversity valued.

The Assessment Team spoke with consumers who did not feel their dignity is upheld when they use the call bell for assistance with personal care and they have to wait for a lengthy period of time before assistance is provided. There was evidence from consumers/representatives that this was resulting in personal care accidents that leave the consumers uncomfortable and humiliated. In addition, the Assessment Team observed some staff were not communicating with consumers when assisting them with eating or were observed standing and appeared preoccupied watching the television.

The Approved Provider submitted a response relating to the findings of the Assessment Team disagreeing with the Assessment Teams findings. The provider furnished call bell data and diagnoses of cognitive impairment for the consumers sampled. However, as the report’s findings were collected from more than one source, and information received reports that call bells are turned off. Therefore, the Approved Provider has not demonstrated that each consumer is treated with dignity and respect.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

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

*Care and services are culturally safe.*

The Assessment Team found that overall consumers provided feedback they can celebrate days that are meaningful to their culture or religion. Staff were able to provide examples of how they implement cultural awareness in their everyday practice and how they recognise diversity to provide services that are meaningful to the consumer.

#### The Assessment Team interviewed staff who confirmed consumers, or their representatives that are new to the service are involved in the admission process at the service. Initial discussions with staff include identifying family connections, their cultural beliefs and preferred customs.

Staff said Catholic consumers attend a worship service in the service every Thursday. In addition, there is music appreciation activities for Greek and Italian music. Lifestyle staff said they also celebrate Orthodox Easter for Greek, however since the COVID-19 pandemic, they are unable to arrange Greek Orthodox services and haven’t tried online services either. However, there were some representatives who did not feel that their consumer had their culturally appropriate needs met.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider submitted clarifying information in relation to the concerns raised by the representatives. This in turn, has provided evidence to demonstrate compliance with this requirement.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated care and services are culturally safe.

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

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

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

The Assessment Team found that some of the consumers sampled said they are supported by staff to exercise choice and independence. This included making connections with others to maintain relationships of choice. Consumer feedback showed a consumer was supported in their choice to maintain a relationship. Other consumers were supported to wear clothes of choice, attend activities of choice and are supported to pursue a musical. In addition, one consumer spoke highly of being supported to remain as independent as possible. In contrast, three consumers were dissatisfied with staff not enacting their preferences.

Some care staff interviewed can describe knowledge and understanding of sampled consumers’ preferences and choices and describe how each consumer is supported to make an informed choice about their care and maintain relationships. However, the Assessment Team did note there were inconsistencies with the implementation of this knowledge.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team. It is important to note that the Assessment Team can and did review documents outside of the dates of the Assessment Team being on site and these have been considered in this decision-making process. After reviewing the evidence that the Approved Provider submitted, whilst it did not completely dispel the findings of the Assessment team as they conjectured, it did provide compelling evidence that consumer choices are recorded and respected in the provision of their care. Furthermore, the Approved Provider was able to provide enough evidence to show that the sampled consumers overall were delivered care according to their preferences. Therefore, there is no evidence of a systemic issue that does not allow for each consumer is to exercise choice and independence.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated each consumer is supported to exercise choice and independence, including to:

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

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

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

The Assessment Team found that consumers are supported to take risks to enable them to live their best life. Staff interviews, and care plans reviewed identified that consumers are supported to undertake activities that may involve risk.

Management interviewed were able to describe the current risk management plan in place at the service to support consumers who choose to take risks to live their best lives. Management said that the general process for risk-taking in the service includes risk assessment by a heath professional after a case conference.

Review of the care and service plans for consumers sampled recorded the risk that consumers wished to take and detailed how they were supported to make these decisions and the strategies in place to support them. In addition, consumer risk assessments and management plans include a list of people who participated in the risk discussion, a description of the choice and benefits for the consumer, a risk analysis and action plan to minimise harm.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated each consumer is supported to take risks to enable them to live the best life they can.

### Requirement 1(3)(e) Non-compliant

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

The Assessment Team found that most consumers/representatives interviewed confirmed they did not receive accurate information that helps them to make day to day decisions about their care and services. They also did not consider the service provides them with information that is clear and easy to understand and helps them exercise choice. Whilst meetings with consumers and their representatives are regularly held, the service was unable to provide an effective information system with consumers and representatives who have a language barrier.

Most of the representatives interviewed raised concerns about communication systems for consumers who have communication difficulties. For example; adjusting communication strategies where deterioration in condition has occurred and communicating with consumers who predominantly speak another language.

Whilst most staff are aware of communication strategies including picture cards, translator applications, or interpreting services most staff tend not to use them to communicate. One care staff member said if they need to communicate with consumers from a culturally and linguistically diverse background they use body language.

The Assessment Team found that consumer who do not speak English attended consumer meetings held at the Service. Management were asked for information about strategies in terms of meeting minutes and newsletters for consumers/representatives who can’t speak English. Management said they use the translator application if requested, but they did not provide an example.

Picture cards were observed in some consumers’ rooms who do not speak English fluently and have a cognitive impairment, however, staff were not observed using these as prompts to communicate with consumers. In addition, the Assessment Team observed most information posted on the walls of the Service were in English only.

The Approved Provider submitted a response relating to the findings of the Assessment Team. Whilst this information provided some clarity and context to some of the examples provided by the Assessment Team, the Approved Provider did not dispute the overall finding. From the evidence supplied by the Assessment Team and the Approved Provider it does appear that the communication is not always clear and easy to understand especially in relation for the consumers who have no or limited ability to speak English.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.

### Requirement 1(3)(f) Non-compliant

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

#### The Assessment Team found that most sampled consumers and representatives confirmed their privacy was respected during personal care. Consumers believe their personal information is kept confidential and staff provided examples of how they protect a consumer’s privacy. However, The Assessment Team observed that consumers’ privacy and confidentiality were not always protected in practice.

Staff were able to describe ways they respect the personal privacy of consumers. The nursing station rooms are locked by a keypad for security and confidentiality purposes. However, the Assessment Team observed a couple of nursing stations remained open and nursing station computers remained logged on while not in use.

Furthermore, the Assessment Team observed staff assisting a consumer where this personal care was provided in a shared room in without curtain screening. This was raised with management who acknowledged this was not usual or best practice.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider did not dispute the overall finding. It is acknowledged however that the care provision that was provided to the consumer as seen by the Assessment Team may have been an isolated incident. However, this was not the only evidence provided to show there is a need for an improvement in maintaining consumer privacy and confidentially.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated each consumer’s privacy is respected and personal information is kept confidential.

# STANDARD 2 COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Most sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. Consumers/representatives confirmed they were included in assessment and planning and discussions about care. However, they said they were not offered a copy of their care plan, have not been provided a copy or were waiting to be sent a copy.

Assessment and care planning do not adequately address all areas of care and services and does not address consumers’ current needs. Comprehensive review of care plans is not conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals or preferences of consumers.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

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

The Assessment team found that the organisation has policies and procedures and processes to guide staff practice in relation to conducting assessments and developing care plans. Evidence provided showed they are consistently followed by staff. Consumers have care plans that address specific risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services. Consumers/representatives confirmed they are involved in care planning.

For the consumers sampled, care and service records provided evidence of comprehensive assessment and care planning that considers risk to the consumer’s health and well-being including when a consumer first enters the service.

Staff confirmed that assessment and planning is done in collaboration with consumers/representatives. They said they ensure that the care plan reflects consumers current needs and assessments they have completed. In addition, management said assessment and planning commences from the day of admission. They said an interim care plan and assessments are completed and this guides the care provided.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

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

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

The Assessment Team found that from the consumers sampled assessment and care planning does not adequately address all areas of care and services and does not address consumers’ individual preferences or current needs. In contrast, most consumers/representatives said they have had an opportunity to communicate end of life care wishes with the staff. In addition, staff interviewed were able to describe what was important for consumers in terms of personal and clinical care.

Staff and management said conversations about end of life and advanced care planning were often difficult. However, they try to have the discussions as early as possible. Most consumers have an advance care directive or plan and the remaining consumers are in process for being put in place. In addition, signed copies of advance care plans or directives were observed in the electronic documentation system.

The organisation has written materials that support staff to undertake assessment and planning and in particular, end of life planning which directs staff to relevant processes for completing the care planning assessments. The materials incorporate links to external organisations and peak bodies for additional reading and best practice guidance.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team including documented evidence. After reviewing the evidence that the Approved Provider submitted, it clearly provided additional information and context as to why the sampled consumer’s care plans may not have reflected some needs and preferences. This evidence was satisfactory in demonstrating the Approved Provider is using assessment and planning to identify and address the consumer’s current needs, goals and preferences.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

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

*The organisation demonstrates that assessment and planning:*

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

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

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

The Assessment Team found that the service has processes in place to enable outcomes of assessment and planning to be documented on a care and services plan and communicated to the consumer. Case conference documentation supports this is occurring. However, consumers/representatives provided feedback they were not offered a copy of their care plan or have been provided a copy.

For the consumers sampled review of the care and services documentation reflected outcomes of assessment and planning are communicated to the consumer/representative and they confirmed they are aware of their care plans. Care plans are written in a format that is easy for the consumers and representatives to understand. Consumers and representatives are offered copies of their care plan during case conferences and can access the care plan whenever they request it. In addition, consumers/representatives confirmed they had been offered copies of their care plan.

Staff said they communicate outcomes of care planning to consumers directly or to their representatives either face to face or via the telephone. In addition, consumers/representatives are offered copies of the care plan during case conferences. This is documented on the case conferencing document on the service’s electronic care planning system.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team including documented evidence. After reviewing the evidence that the Approved Provider submitted and considering that the evidence supplied by the Assessment Team it predominantly shows that the outcomes of assessment and planning are effectively communicated to the consumer and consumers/representatives are involved in the process. In addition, the plan is available to consumers.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

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

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

The Assessment Team found that the service demonstrated care plans are being reviewed on a regular basis and case conferences are occurring. However, it was noted that reviews of care plans are not being conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals, or preferences of consumers. The service’s care plan evaluation schedule did not provide any information regarding completed care evaluations or case conferences.

For the consumers sampled, care and services plans do not show evidence of comprehensive review for effectiveness when circumstances change, when incidents occur or when the needs of consumers changes. This was seen in relation to care provision and behavioural incidents.

Staff said registered nurses are responsible for updating the care plans. They said they provide any feedback to aid in this process. Care plans are reviewed every four months by the clinical care co-ordinator. This is done in conjunction with a case conferences every four months as well. The Service is also currently making changes to this process to allow for more staff to be trained to complete the reviews to ensure they are completed as planned. In practice however, there is no other detail showing whether the reviews or case conferences had been completed. Management acknowledged they had identified this issue and were working towards creating a better schedule with this information included in it.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team including documented evidence. The documents mostly related to improvements that had been made since the time of the site audit. It also provided some context around some of the individual consumers sampled by the Assessment Team. Whilst the decision is made on the information evidenced by the Assessment Team there is also evidence to show that the Approved Provider is in the process of addressing some of the issues associated with capturing information when there are changes to consumer care needs and preferences. This has been achieved by their regular improvement process. Therefore, there is no evidence to suggest there is a systemic, reoccurring issue in relation to this requirement.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Overall sampled consumers considered that they receive personal care and clinical care that is safe and right for them. Consumers generally confirmed that they have access to a doctor or other health professional when they need it. However, the Assessment Team found that consumers do not receive individualised care that is safe, effective, tailored to their specific needs and preferences or best practice. In addition, the service did not demonstrate high impact high prevalence risks are not managed appropriately.

Sharing of information about consumer care does not always occur. Referrals to relevant health professionals are not always undertaken or are not undertaken in a timely manner. In addition, the organisation’s practices to manage an outbreak and minimise infection related risks are not always followed and measures to minimise the spread of infection are not always followed.

The Quality Standard is assessed as Non-compliant as five of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that the service was not able to demonstrate consumers get safe and effective personal care or clinical care that is tailored to their needs and preferences or is best practice. This specifically related to behaviour management, pressure injuries and diabetes management.

Review of care and service records does not support that the consumers sampled receive individualised care that is safe, effective, tailored to their specific needs and preferences or best practice. The service was not able to demonstrate best practice for wound management and diabetes management. Behaviour support plans did not have triggers listed for one consumer that several behavioural incidents. As another example the Assessment team found that after a consumer fall a falls risk assessment was completed, and they were reviewed by the physiotherapist. However, a review of his neurological observations showed staff had not followed the organisation’s post falls management policy.

The Assessment Team also saw that information management was not optimal for the consumers care needs. This resulted in a consumer allergy not being identified when required. They also saw that wound management was not best practice as wounds were not reviewed as per the regime. In addition, medication reviews were not consistently occurring.

In contrast, consumers/representative provided positive feedback about the care they are receiving and were all happy with the care being provided. In addition, staff are aware of consumers who require behaviour management techniques, wound dressings and who had current infections. They were able to describe which consumers were using restrictive practices and how often the consumers were reviewed. Staff said they are also provided best practice training and guidance and they follow the policies and procedures which are based on best practice.

The use of restraint is also minimised at the Service. The service has a self-assessment tool and is being used. Chemical and environmental restraint documentation showed discussions had been held with their representatives and consent forms had been signed. All consumers sampled had a current and up to date behaviour support plan in place.

A review of the care and services documentation for consumers receiving pain management showed that they are being managed appropriately. Pain assessments are being undertaken and consumers are receiving adequate pain relief.

The Approved Provider submitted a detailed response relating to the findings of the Assessment Team including documented evidence. This evidence did provide some context in relation to some of the consumers sampled, particularly in relation to diabetes management. It is also acknowledged that in the areas of restrictive practices and pain management are safe and effective for consumers and that consumer feedback was positive in relation to the care they are receiving. However, based on the evidence from the Assessment Team, consumer care information management, wound management, behaviour management and falls management which does optimise consumer health and wellbeing.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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.

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

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

The Assessment Team found that the service has systems in place to manage high impact, high prevalence risks. However, a review of care and services documentation showed these risks are not being managed appropriately. Consumers with wounds are not being reviewed regularly, consumers who have had falls have not had neurological observations taken as per the organisation’s policy. Consumers provided negative feedback about how the service is managing their risks.

The Service identified skin integrity, falls and unplanned weight loss as their high impact high prevalence risks. For consumers sampled, care and services documentation showed that these risks were not being managed appropriately. Wounds have not been treated as per regime. In relation to falls management, a review of care and services documentation showed that staff are not following the related policies and consumers are not appropriately assessed after having a fall.

In contrast, A review of care and service documentation in relation to unplanned weight loss, showed this is being followed. Consumers who have lost weight have been referred to or have been offered a referral to a dietician and monthly weights have been attended.

#### Representative feedback did highlight an issue reacting to weight loss with staff unable consistently assist consumers with eating foods and there no record being kept how much they are eating.

Staff are aware of high prevalence or high impact risks associated with the care of consumers and can describe interventions for care in line with their care plans. Management said high impact, high prevalence risks are identified through risk assessments, accident/incident reports and from feedback from the consumers. In addition, management could escribe how they mitigate the high prevalent risk including skin integrity, falls and unplanned weight loss.

The Service trends, analyses and responds to high impact high prevalence risks through their monthly key performance indicators which are undertaken by the director of nursing. These trends are discussed at the clinical meetings and other appropriate meetings such as the falls meeting and medication advisory meeting.

The Approved Provider submitted a detailed response relating to the findings of the Assessment Team including documented evidence. This evidence did provide some context in relation to some of the consumers sampled. It is also acknowledged that the Approved Provider does have the ability to identify and respond to high prevalent risks and where deficiencies had been noted since the site audit that they have been rectified. However, based on the evidence from the Assessment Team at the time of the site audit, falls and unplanned weight loss risk mitigation is not effectively and consistently managed for consumers.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer.

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

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

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

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

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

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

#### The Assessment Team found that whilst there are systems in place for communicating information about the care of consumers, these have not been effective for all consumers sampled. Sharing of information has not always occurred and information in consumer care and service records and reports is incorrect or inconsistent. Information about consumers condition is not always shared with the medical officer for all consumers sampled.

Care and services documentation reviewed for sampled consumers did not always provide an adequate handover of consumer needs and preferences. This included behaviour management and after incidents had occurred that impacted consumers. In addition, there was also representative feedback that communication during a COVID-19 outbreak was not accurate.

Staff said they have access to consumers’ progress notes and care plans. They said they receive information about consumers during handover or they get it from the handover sheet. Staff also said they communicate with medical officers or the other members of the team face to face, via phone or via email. In addition, the Service utilises a handover sheet which contains important information regarding each consumer. Staff were observed having a copy and using it to get information.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider submitted some information that provided context to some of the consumer/representative feedback to the Assessment Team. It is also acknowledged that Assessment Team did see that staff were using the Service’s communication system to assist with the care provided to consumers during the site audit. However, the information submitted did not fully dispel the findings of the Assessment Team.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

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

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

The Assessment Team found that the care and services documentation showed appropriate referrals to relevant health professionals were not always undertaken or were not undertaken in a timely manner. There was also mixed consumer/representative feedback regarding access to health professionals. This predominantly related to emotional support and some timely clinical referrals. In addition, from the consumers sampled, care planning documents did not evidence the input ofdoctors and allied health providers and referrals where needed.

Staff were able to describe the processes for referring to other health professionals. Staff also said they involve different health care providers such as physiotherapists, medical officers and dietitians in their consumer’s care when needed.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider submitted information and document evidence relating to some of the consumers/representatives sampled. It is acknowledged that this evidence did provide context and explanation for some of the actions taken by the Approved Provider. However, the information provided did not dispel all the findings of the Assessment Team particularly in relation to timely referrals.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services.

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found that the service has systems in place to manage an outbreak and minimise infection related risks. The service has practices in place to minimise the spread of infection and promote appropriate prescribing and usage of antibiotics. However, these practices were not always followed. Issues were identified in relation to COVID-19 preparedness and prevention. Staff were observed breaching infection control protocol and a representative said that staff worked with symptoms of COVID-19.

Staff were interviewed in relation to practices minimising the use of antibiotics, promote and support optimal care, and reduce the risk of increasing resistance to antibiotics. Overall, they demonstrated they have a good understanding on the principles of antimicrobial stewardship and have access to relevant information on the expectations set by the organisation.

All staff interviewed said that they had completed the mandatory training for infection control and COVID-19 as per NSW Health Department guidelines. Staff said they are provided with appropriate supplies and have no issues obtaining PPE. In addition, cleaning staff interviewed were aware of cleaning protocols to minimise the spread of infection.

The Assessment Team also found that the kitchen and laundry areas had good infection controls protocols in place and that there was an adequate number of bins. However, clinical waste bins and cytotoxic bin were observed to be unlocked. This was raised with management who were responsive, and the bins were subsequently locked.

However, the Assessment Team observed gaps on site with the infection control protocols implemented as COVID-19 cases began to appear at the Service. The Assessment Team found that the service had not dedicated staff to a single level, more staff were taking their break in the one room or taking breaks outside. Several staff members were observed to be touching their face, eye protection/mask or wearing masks under their noses or chins. In addition, they were also observed not washing their hands after providing consumer care or administering medications before attending to another consumer. This may have been because many hand sanitisers were empty or not working.

Furthermore, lifters and other shared equipment were observed to have wipes on them or nearby. While the wipes were accessible, they were not always used. A staff member was observed pushing a lifter into the storage area after using it for a consumer without wiping it down.

The Approved Provider submitted a response relating to the findings of the Assessment Team. This provided contextual information and some areas of improvement that have been made since the site audit. However, the information provided did not dispel the findings of the Assessment Team from the day of the site audit which means that the Approve Provider has been unable to demonstrate compliance with this requirement.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated minimisation of infection related risks through implementing:

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

# STANDARD 4 NON-COMPLIANTServices and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service and staff were asked about their understanding and application of the requirements. The team also examined relevant documents.

Some sampled consumers did not consider that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Feedback also indicated not all consumers are supported to keep in touch with people who are important to them. Representatives are unable to contact the service in the evenings to check on consumers’ wellbeing. In addition, some consumers are not receiving services and supports for daily living or being referred to external services when required that promote their emotional, spiritual and psychological wellbeing.

Several consumers interviewed advised that they did not like the food, meals were not served to consumers at times and sometimes staff are too busy to assist consumers to eat as required.

Consumers were observed engaging, participating, watching and enjoying group activities in the mornings and afternoons. Consumer and representative feedback included high praise for the lifestyle staff members and that they have been a constant positive aspect of the service for many years.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

## Assessment of Standard 4 Requirements

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

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

The Assessment Team found that consumers/representatives indicated some consumers do not always get safe and effective services that meet their needs, goals and preferences. Consumers’ needs, goals and preferences are not always recorded in the care plan and comments are standard and not individualised for each consumer. Some consumers/representatives interviewed said consumers do not always effective services and supports for daily living. Some of the feedback provided included consumer food service, ability to get outdoors, laundry.

Care planning documentation included information about the services and supports consumers need to help them do the things they want to do. Consumer needs and preferences are identified but sometimes there are no strategies recorded about how to achieve these.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team including documented evidence. After reviewing the evidence that the Approved Provider submitted and considering that the evidence supplied by the Assessment Team it is difficult to determine that there is clear, systemic issue that is impacting consumers getting safe and effective services and supports for daily living. The Approved Provider has presented enough evidence to demonstrate that care planning is utilised to capture the consumer’s needs, goals and preferences and is individualised. There is also no evidence to suggest that the consumer’s safety is at risk through the inadequate provision of services and supports. Considering all this the evidence does not substantiate a shortfall in this requirement.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.

### Requirement 4(3)(b) Non-compliant

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

The Assessment Team found that some consumers are not receiving services and supports for daily living that promote their emotional, spiritual and psychological wellbeing. The Assessment Team had direct feedback from consumers saying they were feeling unsupported in terms of emotional wellbeing. In addition, information about consumers is not always included in the leisure care plan to support their emotional, spiritual and psychological wellbeing.

Management acknowledged emotional, spiritual and psychological information about consumers could be difficult for staff visiting medical professional requiring it is spread across varying documents and there are no specific care plan domains for emotional, spiritual and psychological wellbeing. They are currently being inconsistently recorded in different areas of the care plan. The Service is currently addressing this situation.

Lifestyle staff articulated comprehensive information about consumers sampled in relation to their cultural identity, spiritual and emotional needs and how services and supports are provided to best meet their needs. They also articulated several other examples relating to special needs of other consumers and how those special needs are met.

The Approved Provider submitted a response relating to the findings of the Assessment Team. It is acknowledged that the Approved Provider has had difficulties with their information management system which is being addressed and that they are have also addressed some of the consumer concerns since the site audit. However, with consumers experiencing emotional and psychological concerns that have not been met consistently or in a timely manner the Approved Provider cannot demonstrate they are consistently providing services and supports for consumers emotional and psychological wellbeing.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

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

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

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

The Assessment Team found that consumers are not always supported in their personal relationships with family outside the service and not always supported to do things of interest to them. Care planning documents for consumers sampled did not always have information about how to maintain relationships between consumers/representatives and family.

The Assessment Team found from sampled consumers/representatives that some felt they are not always assisted to participate in the community, have social and personal relationships and do things of interest to them. For example, a consumer was never taken into the garden area from upstairs floor which they wanted to access.

Care planning documents reviewed by the Assessment Team for consumers sampled did not always have information about how to maintain relationships between consumers and their representatives and family. Some lacked information on how best to contact or interact with family as preferred by the consumer. In addition, some care plans did not have strategies to maintain relationships that were important to a consumer within the Service. In contrast, one consumer provided very positive feedback about being supported to have a close relationship that was important to them and this was documented in their care plan.

Lifestyle staff articulated comprehensive details about how consumers sampled, and several others, were supported in socialisation and activities within the service. In addition, the Assessment Team observed several group activities during the site audit and that several consumers were engaged and participating in the activities or enjoying watching them.

The Assessment Team reviewed the activities schedule and the monthly consumer/representative meetings which have a standing agenda item and questions for lifestyle. These were reflective of consumer involvement, consumer satisfaction with activities and where preferences were raised these had been actioned.

The Approved Provider submitted a response relating to the findings of the Assessment Team including documented evidence. The evidence that the Approved Provider submitted provided documents and context to dispel some of the issues raised. In addition, the Assessment Team also received positive consumer feedback, documented consumer participation and observed the success of the lifestyle program on the day of the site audit. This combination provides enough evidence to show that overall the consumers impacting consumers getting safe and effective services and supports for daily living.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated services and supports for daily living assist each consumer to:

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

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

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

The Assessment Team found that care planning documents reviewed by the Assessment Team for consumers sampled did not always provide adequate information or information was difficult for staff to find in relation to consumers. However, staff interviewed said there is an electronic procedure where all updates are logged about the changing condition, needs or preferences of each consumer including conditions, needs and preferences relating to services and supports for daily living.

The Approved Provider submitted a response relating to the findings of the Assessment Team including documented evidence. After reviewing the evidence that the Approved Provider submitted and considering that the evidence supplied by the Assessment Team it is difficult to determine that there is clear, systemic issue that is impacting consumers through issues with communication across the organisation and with those sharing consumer care.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

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

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

The Assessment Team felt that consumer/representative feedback indicated that not all consumers receive timely and appropriate referrals to individuals, other organisations and providers of other care and services. However, the service has policies and procedures for making referrals to individuals and providers outside the service which staff are following.

The Approved Provider submitted a response relating to the findings of the Assessment Team including documented evidence. After reviewing the evidence that the Approved Provider submitted and considering that the evidence supplied by the Assessment Team it is difficult to determine that there is clear, systemic issue with the referral process at the Service.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services.

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

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

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The team also examined relevant documents.

Some consumers considered that they feel they belong in the service and feel safe in the service environment.

The Assessment Team observed some aspects of the environment did not align with it being welcoming and optimising each consumer’s sense of belonging, independence, interaction and function. For the consumers who cannot access the garden area and want to, they are restricted to the internal environment which is limiting and does not support enabling their physical and emotional wellbeing.

The Assessment Team observed that the lounge rooms, dining rooms and activities rooms were nicely decorated and welcoming. The dining rooms had tablecloths over dining tables which looked stylish and enhanced the dining experience for consumers when having their meals.

The Quality Standard is assessed as Non-compliant as one of the three specific requirements have been assessed as Non-compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Non-compliant

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

The Assessment team found that some aspects of the environment did not align with it being welcoming and optimising each consumer’s sense of belonging, independence, interaction and function. There were consumer rooms that are not personalised and do not look welcoming. The service does not enable consumers living with dementia to optimise their interactions and function. In addition, there was representative feedback saying that the consumer was unable to access the garden areas when they wanted.

The Assessment Team observed some areas of the service environment to be welcoming and optimise consumer’s function. The dining, lounge and activities rooms were observed to be very welcoming and homely. There is a visitors’ room with a lounge and chairs next to the reception office. In contrast, the Assessment Team observed that the service environment had limited areas for consumers to interact and effective navigational aids. There are no elements included to stimulate sensory engagement, reminiscing or meaningful activity.

The design of the service was observed not to enable independence, interaction and function for consumers living with dementia or cognitive decline. The Assessment Team observed on several occasions that consumers with cognitive decline were walking in the corridors and becoming confused when it was congested with other staff, consumers and visitors. Confusion increased when they could not navigate around people and consumers with mobility aids made it difficult for everyone in congested areas to manoeuvre.

The Approved Provider submitted a response relating to the findings of the Assessment Team. It is acknowledged that the building itself does provide limitations to what improvements can be made. It is also acknowledged that the Approved Provider had no knowledge of an issue relating to access to the gardens for some consumers and would address this issue as a matter of priority. However, the Approved Provider did not submit any evidence in relation to the service design enabling the independence, interaction and function for consumers with dementia. The service environment should support all the consumers considering their individual needs and abilities.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.

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

*The service environment:*

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

The Assessment Team found that the service environment was observed to be safe, clean and well maintained. Most consumers can move freely, both indoors and outdoors. The Assessment Team observed the environment to be very clean and tidy in all areas of the service.

Consumer/representative feedback indicated the environment is always very clean. The Assessment Team also interviewed the maintenance officer who said although they were rushed, they are usually able to manage the preventative maintenance schedule effectively and produced the electronic maintenance schedule that reflected all work was up to date. In addition, the Assessment Team interviewed the organisation’s quality manager who oversees multiple operations for quality including this service’s maintenance work. They were able to explain the environmental inspection procedure and how priority issues are reported to management for quality and monitoring purposes.

Preventative and reactive maintenance work was observed to be carried out during the site audit such as installing the surround for a bain-marie, electronic equipment testing and tagging, storage of mobility equipment and attending to a leaking ceiling.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated the service environment:

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

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

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

The Assessment Team found that the furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumers. For example, the lounge and dining areas included furniture and fittings which were clean, well maintained and decorated the areas nicely. Tables were set out with plenty of space to allow consumers to safely walk and manoeuvre mobility aids or walking chairs between them. The main kitchen and the kitchen equipment and fittings were clean and tidy. The laundry was clean and divided into a dirty laundry area and clean laundry area. The equipment appeared clean and well maintained. Representative feedback also confirmed this.

The Assessment Team reviewed latest environmental inspections demonstrating building, safety, equipment, electrical appliances, housekeeping, chemicals, environment, infection control, manual handling and ergonomics areas are checked.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – asking them about how they raise complaints and the organisation’s response. The team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Most sampled consumers did not consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Some consumers interviewed did not feel they could make complaints as they did not feel safe doing so. In addition, generally the consumers interviewed felt change was not made at the service in response to complaints and feedback and they feel they are constantly repeating themselves.

The Assessment Team reviewed the complaints and feedback register and found numerous complaints were not closed in a timely manner and an open disclosure process was not implemented in practice.

The Quality Standard is assessed as Non-compliant as three of the four specific requirements have been assessed as Non-compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Non-compliant

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

#### The Assessment Team found that generally consumers/representatives interviewed said they did not feel they are encouraged and supported to provide feedback and make complaints. Most of the consumers and representatives interviewed did not consider they were encouraged to provide feedback. Some representatives preferred to remain anonymous as they are not confident that there won’t be any negative consequences if they raise a concern or complaint.

#### One representative said that the Service has not responded to numerous attempts to meet to discuss concerns but there has been no response to the request. Another representative wanted to be anonymous because they were concerned that consumers may be disadvantaged because of reporting complaints. In addition, they did not expect any improvement from the reporting complaints and their complaints were not always considered and determined by management.

Some staff interviewed were aware of how to assist consumers to provide feedback or make a complaint. Most staff said they tend to report directly to a registered nurse when they received a complaint instead of encouraging consumers to fill out a feedback and complaint form.

The Assessment Team reviewed the meeting minutes of the service’s consumer meetings where consumers/representatives are given the opportunity to provide feedback and are reminded of the feedback and complaint forms around the service. However, the Service has a website which does not have an email address or feedback option for consumers to use to contact the service or provide feedback.

The Assessment Team did note an Aged Care Quality and Safety Commission brochure on how to make external complaints displayed in the foyer of the service available in several languages. Feedback and complaint forms outside the management office and at the front entrance foyer. There were suggestion boxes also seen where the continuous improvement forms can be placed anonymously.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider did present additional context to some of the consumer complaints, times frames and the associated actions taken. It is also acknowledged that the Assessment Team did provide evidence that the Approved provider has a system in place for consumers/representatives to provide feedback/complaints to the Service. However, there was many consumer/representative feedbacks where they did not feel supported or encouraged to provide feedback/complaints. This does not support the fulfilment of the competencies for this requirement.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.

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

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

#### The Assessment Team found that whilst some consumers/representatives were not aware of advocates and language services, others were aware of other external methods for raising and resolving complaints and the service demonstrated they provide information on these through a variety of avenues.

Most of the consumers and representatives interviewed confirmed they have been informed of other methods for raising their concerns. Consumers and representatives’ feedback identified access to advocacy services was not widely known but the service provides relevant information in a variety of ways.

Management explained that information is provided to consumers/representatives about the options for providing feedback and making complaints, including accessing external complaints mechanisms, and advocacy services. The manager said translating and interpreting services are also available if requested.

The Assessment Team observed information about complaints to the Commission was available in various languages as well as language service and advocacy information including the Older Person Advocacy Network in English was displayed on notice boards throughout the service. In addition, in the residents meeting minutes includes information about access to advocates and languages services.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

### Requirement 6(3)(c) Non-compliant

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

#### The Assessment Team found that the service could not demonstrate a timely or effective action is taken in response to complaints. The service did not demonstrate that there is an open disclosure practice within the service. Some consumers/ representatives felt that the service has not taken appropriate action in relation to their complaints in a timely manner.

The staff interviewed were not able to describe the service’s open disclosure flow chart nor were they able to describe the service’s complaint and feedback policy and how the policy was used in relation to complaints. Some staff said they received training in open disclosure, but they were not able to describe to open disclosure process and what was required of them in the process. The Assessment Team also saw examples of complaint resolution that did not follow the open disclosure principles. In addition, the complaints register contained numerous complaints which were not closed in a timely manner and the service’s response did not follow the organisation’s open disclosure process.

The Approved Provider submitted a response relating to the findings of the Assessment Team. Whilst the Approved Provider did provide additional context to some of the consumer complaints and the associated actions taken there was an acknowledgement by the Approved Provider that improvements were required, especially in relation to open disclosure. Based on this and the evidence provided by the Assessment Team the Approved Provider has not fully demonstrated that complaints have consistent appropriate action nor the consistent use of open disclosure.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

### Requirement 6(3)(d) Non-compliant

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

The Assessment Team found that the consumers are not confident the organisation used the feedback and complaints to improve the quality of their care and service. Consumers/representatives stated they are increasingly frustrated that the service takes a long time and sometimes not at all to get back to them with follow-up information.

The service has a system for recording feedback and complaints however the service did not demonstrate that they are trending, and analysing complains to improve care and services and to inform continuous improvement.

The Assessment Team identified there were many verbal complaints made in the service the Assessment Team found some verbal complaints were missing in the complaint register even when it was not resolved. In addition, The Assessment Team found there were repeated complaints that were impacting the comfort and dignity of consumers. Although these had been addressed it took several complaints to initiate preventative, effective improvements.

The Approved Provider submitted a response relating to the findings of the Assessment Team. Whilst the Approved Provider did provide additional context to some of the consumer complaints and the associated actions taken there was an acknowledgement by the Approved Provider that improvements were required. The Approved Provider did not provide any further information relating to the review and improvement process that is undertaken systematically. Based on this and the evidence provided by the Assessment Team the Approved Provider has not demonstrated that complaints are reviewed and used to improve consumer outcomes.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated feedback and complaints are reviewed and used to improve the quality of care and services.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

To understand the consumer’s experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Most sampled consumers did not consider that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. Consumers/representatives interviewed felt that staff were rushed, too busy and there were not enough of them. They were also not satisfied with call bell response times. There is a high reliance on agency staff to fill vacant shifts and agency staff are not overly knowledgeable of the consumers or practices at the service.

Some consumers and their representatives felt that staff are kind and caring but some felt not all staff were considerate towards them.

The service was unable to sufficiently demonstrate that the workforce is competent, and the members of the workforce have the knowledge to effectively perform their roles. Consumers and representatives interviewed did not feel confident that all staff have the knowledge of how to perform their roles. In contrast, the service generally demonstrates it has systems for recruitment to ensure they employ skilled staff and meet the requirements of their job roles. There are processes for regular training in core skills that are job specific.

The service has a staff appraisal system and appraisals occur annually for staff once they have completed the probationary period. However, when staff performance issues are identified they are not always addressed by management.

The Quality Standard is assessed as Non-compliant as five of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 7 Requirements

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

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

#### The Assessment Team found that most consumers and representatives interviewed are not satisfied with current staffing sufficiency and call bell response times. They said staff are rushed, busy, stressed and unable to always meet care needs and preferences. This adversely impacts consumer health, wellbeing and dignity where continence needs are not met and safety issues when staff assistance is not available when needed for personal care. One consumer said There are a lot of agency staff and this can create significant communication and language barriers.

#### Staff said not all shifts are replaced, they rush and cannot always meet consumer care needs and preferences. There is a high reliance on agency staff who do not know the consumers well. Rostering documentation shows currently high levels of shift vacancies and not all vacant shifts can be replaced. Call bell response times regularly exceed organisational expectations. One staff member said the workload is very heavy and there are not enough staff and the service constantly works short with registered nurses and care staff. Management is recruiting staff and have stated the current roster is under review. However, the current staffing level and skill mix is not adequate to ensure effective staff response and the delivery of safe and quality care and services.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team. The provider furnished call bell data and feedback survey results for the consumers sampled. In addition, the Approved Provider did provide information about difficulties with staffing and having the need use agency staff. However, there is a large sample of consumers and staff that provided specific feedback on staffing levels. Therefore, the Approved Provider is unable to substantiate that they consistently enable the right staffing mix and levels so that staff are enabled to deliver and manage safe and quality consumer care and services.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

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

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

The Assessment Team found that consumers and their representatives interviewed, and observations made show some staff are kind, caring and respectful to consumers. However, one consumer and one representative raised a concern about staff not being kind and caring.

Feedback from consumers and representatives interviewed indicated staff are mostly kind, caring and respectful. Staff were observed to be kind and caring with their interactions with the consumers. However, one consumer and one representative raised some concern about staff being kind and caring. One representative said the care staff who have been at the service a long time are very kind and caring however the service uses a lot of agency staff who do not know the consumer care needs very well and their interactions can be short and sharp. In addition, the Assessment Team saw two staff consumer interaction that could have been more respectful and caring.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider submitted the feedback survey results but also acknowledged they would investigate consumer feedback. Again, there is a large sample of consumers and Assessment Team observations to indicate that the Approved Provider should look to improve staff interaction, particularly in relation to agency staff. Therefore, the Approved Provider is unable to substantiate that there is consistency in kind and respectful staff interactions.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

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

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

The Assessment Team found from interviews, on site observations and document reviews that the workforce is not always competent and does not always have the knowledge or training to support them to effectively perform their roles. Consumers/representatives interviewed were not always confident that staff are skilled and competent to adequately meet their care needs. They provided examples where personal and clinical care was not delivered being attentive to their individual needs. These were also directly observed by the Assessment Team during the site audit.

Management could describe how they determine whether permanent staff are competent and capable in their roles which is through observation, annual staff appraisals and feedback. In addition, staff files sampled indicate that all permanent employees have completed the training required by the Service to maintain competency. However, for agency staff, the orientation checklist is completed but there is no evaluation of whether the staff member understood the information. In addition, the Assessment Team found documented evidence suggesting an increased number of incidents attributed to agency staff.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider feedback predominantly acknowledged the feedback. Given this and the large sample of consumers and Assessment Team observations, the Approved Provider is unable to substantiate that all the staff are competent at effectively performing their roles.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

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

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

The Assessment Team found generally, the organisation demonstrates it has systems for recruitment to ensure they employ skilled staff and meet the requirements of their job roles. However, gaps in staff knowledge and skills were identified in the provision of care and the service’s high use of agency staff means not all staff are receiving the training requirements identified by the service.

#### From representative and staff interviews staff training deficits included equipment/system use, engaging consumers who have English as a second language, wound care and provision of some areas of personal care.

Management advised the organisation’s base calendar of training is set for the year and other training needs are added depending on the consumer mix at the service. This schedule is sent out electronically to all staff. This training documented was evidenced by the Assessment Team. In addition, management advised agency staff were not trained but are required to have completed all mandatory training including SIRS, infection control and manual handling. An orientation checklist is completed for all new agency staff as shown to the Assessment Team. However, agency staff are not required to complete service specific identified training with the result training deficits in the identified areas are not being addressed by all those providing care and services.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider feedback predominantly acknowledged the feedback. It is acknowledged that the Approved Provider does have systems in place that ensure training is provided and has acted appropriately where it has known of specific training requirements. However, the Assessment Team findings do indicate that the Approved Provider still needs to address some competency areas for staff thus improving consumer outcomes.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

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

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

The Assessment Team found that staff performance reviews occur annually for all staff once they have completed the probationary period. However, when staff performance issues are identified they are not always addressed by management.

Management advised the appraisals are conducted to review performance and as an opportunity to identify staff skills and further develop their expertise by identifying further training opportunities. The Assessment Team evidenced the service has position descriptions, appraisal schedule including both last and next appraisal due dates. However, management could not provide evidence of how consumer feedback has been incorporated into staff performance reviews.

The Assessment Team evidenced that there were some consumer feedback and incidents that were not used as opportunities to performance manage staff shortfalls. In addition, not all instances of staff performance issues are addressed when they arise and recorded so they can be actioned.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider feedback predominantly acknowledged the Assessment Team findings. It is acknowledged that the Approved Provider does have an effective system where there is regular assessment, monitoring and review of the performance of each staff member. However, the Approved Provider was unable to demonstrate how this process is used to improve staff performance where issues have been identified.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Most sampled consumers did not consider that the organisation is well run and that they can partner in improving the delivery of care and services. Consumers were unable to provide examples of how they are involved in the development, delivery of evaluation of care and services.

The governing body has systems and processes in place to deliver safe, quality inclusive care and services. However, the service has not been able to demonstrate that it has effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints.

The service has organisational risk management systems and practices in place to manage high impact, high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect, and supporting consumers to live the best life they can. However, these processes are not always followed by staff. In addition, the service has a clinical governance framework in place however open disclosure principles are not followed.

The Quality Standard is assessed as Non-compliant as three of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

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

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

The Assessment Team found that the service was not able to demonstrate that consumers are engaged in the development, delivery and evaluation of care and services or supported in that engagement.

The Assessment Team interviewed management who advised the service does not have consumer representation at board meetings, staff recruitment or training. Management was able to show engagement of consumers through surveys, food forums, feedback mechanisms and consumer meetings. Management said that consumer engagement in development, delivery and evaluation of care and services is under review at an organisational level and it was anticipated this would be introduced at the service in the future.

The Approved Provider submitted a substantial response relating to the findings of the Assessment Team including documented evidence. After reviewing the evidence that the Approved Provider submitted and considering that the evidence supplied by the Assessment Team it is clear that the Approved Provider has mechanisms in place to seek the engagement of consumers in the development, delivery and evaluation of their care and services. In addition, as found by the Assessment Team the Approved Provider is currently reviewing the consumer engagement process to improve these mechanisms. Overall, this substantiates that the Approved Provider is actively seeking a partnership with consumers/representatives to develop, deliver and evaluate care and service provision.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

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

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

The Assessment Team found that the governing body has systems and processes in place to deliver safe quality inclusive care and services.

Management stated that changes made in the last 6 months driven by the board mostly relate to COVID-19. Information was sent out through staff emails and alerts. They advised the Chief Executive Officer (CEO) is included in the electronic document management system alerts and was kept abreast of all updates and communications. Management said other changes driven by the board included staff retention strategies as they are aware of the staffing situation and the impact to consumers.

Management advised that their quality team has an array of audits by which they assess the service’s performance against the Quality Standards. Depending on their role, various staff members undertake audits. The result of these are presented at the executive meetings at which the CEO/board attend. Any concerns of non-compliance across the standards is raised and actions taken.

Management stated that CEO and board are aware of the situation and the impact to consumers and continue to seek other ways of retaining and recruiting staff. They said they are going to undertake a review of the complete roster, but this has not yet commenced.

The Approved Provider submitted a response relating to the findings of the Assessment Team reiterating that the management team and the board are dedicated to promoting and acknowledge that the Assessment Team has seen some areas requiring improvement. In considering the compliance for this requirement it is apparent from the evidence that whilst there may be some room for improvement in the delivery of care and services the governing body is accountable and has mechanisms in place to ensure they are informed and continuously improving so that the care that is delivered is safe, inclusive and high quality.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

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

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

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

The Assessment Team found that the service has not been able to demonstrate that it has effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints.

In relation to information management, care staff interviewed said they can access information during shift handovers. Information about the changing COVID-19 updates are not always communicated to consumers/representatives. In addition, information in consumer care and services documentation is not always correct impacting consumer care.

In relation to continuous improvement, management stated that opportunities for continuous improvement are identified though through feedback from consumers and representatives, survey results, audits, feedback from staff, monitoring of key performance indicators and incidents. However, the Assessment Team found that consumer feedback/complaints and incidents were not filtering through to the Plan for Continuous Improvement

In relation to financial management, the Assessment Team found the CEO/board are very receptive to expenditure to support changing needs of consumers. In response to the higher acuity of consumers several new comfort chairs were purchased in addition to normal capital expenditure. The Assessment Team sighted evidence of these purchases.

In relation to workforce, the service did not demonstrate that it has sufficient workforce governance arrangements for managing the quality of care and services for consumers. The CEO/board are aware of the insufficient staffing levels at the service however the staffing issues remain evident.

#### In relation to regulatory compliance, the organisation has a registered nurse responsible for document controls who monitors all areas of the service for regulatory updates and then disseminates information about any changes to staff and updates the relevant organisational document including policies to reflect the changes. In addition, management communicate changes in legislation to senior staff through meetings and emails and to the broader staff through message boards, human resources messaging system, the electronic care planning system and training. The organisation has rolled out specific training to the staff for the SIRS and incident management and has updated/developed policies to support the implementation of the new legislation.

Lastly, in relation to feedback and complaints governance, there is no consistent approach to analysis and trending of feedback and complaints data, monitoring and review of complaint resolution actions or closing matters. Complainants are not consistently asked whether they are satisfied with the outcome of concerns. Refer to Standard 6 for more detailed information.

The service has not been able to demonstrate that it has effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider information did not conclusively provide any information to dispute the Assessment Team findings. Therefore, the Approved Provider has not been able to demonstrate that it has effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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.

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

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

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

The Assessment Team found that the service has a documented risk management framework that defines the process to be followed to identify, assess and treat risk, however this is not always being followed by staff. Management and staff were able to demonstrate a knowledge of their responsibilities in relation to the SIRS and the accompanying legislative reporting requirements, but they did not demonstrate they followed this for a consumer.

The service has systems in place to manage high impact, high prevalence risks. However, a review of care and services documentation showed these risks are not being managed appropriately. The Assessment Team saw that this was occurring with wounds and falls. In addition, a review of the incident management system and risk register shows this has not always resulted in highlighted risks so that they are minimised.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider information did not conclusively provide any information to dispute the overall Assessment Team findings. Therefore, the Approved Provider has not been able to demonstrate that it has effective organisation wide governance systems specifically relating to high impact and high prevalence risk and incident management.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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.

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

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

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

The Assessment Team found that the organisation has not been able to ensure that the clinical governance framework been effective in its open disclosure process.

The organisation has a documented clinical governance framework including a policy relating to antimicrobial stewardship, a policy relating to minimising the use of restraint and an open disclosure policy.

Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Staff had been educated about the policies and were able to provide some examples of their relevance to their work. Open disclosure was not well understood, and the principles not followed by staff consistently.

Management were asked what changes had been made to the way that care and service were planned, delivered or evaluated because of the implementation of these policies. One example provided was that the service has an agreement with an external medication management review provider that assists them with regular reviews and provides a monthly spreadsheet on antimicrobial medication usage. This spreadsheet is cross referenced against the service’s infections register and discussed at the monthly clinical governance and risk meetings.

The Approved Provider submitted a response relating to the findings of the Assessment Team. This provided information and documentation to provide context about some consumers interviewed by the Assessment Team. It is also acknowledged that the Approved Provider does have a functioning clinical governance framework that is effective for antimicrobial stewardship. In addition, it is noted that the Assessment Team did not provide evidence in relation to minimising the use of restraint. However, the Approved Provider has not been able to demonstrate a clear, consistent, functioning governance framework for open disclosure.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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.

# 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.

### Requirement 1(3)(a)

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

* Ensure staff are treating all consumers with respect and dignity and if time pressures are the cause that this is investigated and improved so staff can have the ability to treat all consumers with dignity and respect.
* Ensure consumers are cared for as required to minimise personal care accidents that leave the consumers uncomfortable and humiliated.
* Seek consumer feedback when personal care accidents occur and seek to improve their care based on the feedback.

### 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.

* Review communication practise for consumers that have limited or no ability to speak English. This should extend to signage and consumer meetings.
* Conduct more training for staff so that they know how best to communicate with consumers with no or limited English speaking and ensure that these are being used in practice.
* Ensure staff are using techniques to communicate with consumer that is appropriate for each consumer and their communication ability.

### Requirement 1(3)(f)

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

* Review nursing station practices and remind staff of the importance of maintaining confidentially in the nursing station area.
* Ensure staff are working as a team to keep each other in check and can immediately stop inappropriate care practices that impact consumer privacy conversations as they are happening and feel confident and supported enough to do so.

### 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.
* Review, improve and deliver safe and effective clinical care. This would include but is not limited to the areas of wound management behaviour/incident management.
* Review staff training to ensure that it is delivery information relating to best practice.
* Review and reduce the use of psychotropic medications in relation to restrictive practices and ensure staff are fully trained to understand their appropriate use.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(b)

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

* Look to improve the risk mitigation strategies for consumers especially in relation to falls and unplanned weight loss.
* Ensure that all improvements are applied in practice consistently.

### 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.

* Complete a review of the communication across the organisation in relation to consumer’s condition, needs and preferences. This should include seeking consumer/representative feedback to ensure accuracy.
* Investigate the feedback provided by consumers/representatives and use that to inform the Service’s plan for continuous improvement.

### Requirement 3(3)(f)

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

* Review and improve referrals to relevant health professionals as needed to care for consumers and ensure they are undertaken in a timely manner.
* Seek feedback from consumers to ensure they are receiving the referrals they need and how this process could be improved.

### 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.*
* Review infection controls practices.
* Train an IPC lead as a priority.
* Develop, implement and the continuously review processes to capture and trend infection rates.
* Ensure that the information is captured to actively improve infection control and reduce the use of antibiotics.

### Requirement 4(3)(b)

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

* The Approved Provider needs to improve the daily living for each consumer in relation to psychological well-being, looking at trauma and grief support.
* Seek feedback from consumers directly to ask how their emotional, spiritual and psychological well-being could be improved.
* Ensure that there is focused, individualised improvement to the daily living for each consumer in relation to emotional, spiritual and psychological well-being and that this is applied consistently.

### 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.

* The Approved Provider needs to improve independence, interaction specifically for consumers with dementia.
* Seek feedback from consumers directly to ask how their sense of belonging and independence.

### Requirement 6(3)(a)

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

* Seek feedback from consumers/representatives to ask how the organisation can better encourage and support feedback/complaints and use for continuous improvement.
* Review the complaints and feedback process to ensure timely responses and to ascertain where improvements in efficiencies could be made so that consumers/representatives feel that they will be heard, and issues resolved.

### Requirement 6(3)(c)

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

* Review the timeliness of complaint responses and seek feedback from the consumer to ensure it has been resolved to their satisfaction.
* Review the complaints and feedback process to ensure open disclosure is always used.
* Ensure staff are all familiar with open disclosure to ensure that it is readily used.

### Requirement 6(3)(d)

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

* Look at ways to ensure that there is a systematic, consistent, functioning avenue to ensure that feedback/complaints are used for improving the quality of care and services provided to consumers.

### 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.*

* Continue to look for ways to attract and retain qualified staff.
* Seek regular, personalised feedback from consumers/representatives to more readily know how staff shortages may be impacting the quality of consumer care.
* Seek honest staff feedback on staffing level, particularly after agency staff have worked.
* Ensure agency staff orientation includes communicating with consumers who have limited or no English.

### Requirement 7(3)(b)

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

* Seek regular, personalised feedback from consumers/representatives to more readily know how all staff (including agency staff) are interacting with the consumers.
* Ensure that feedback is responded to as swiftly as possible to eliminate reoccurrence.
* Encourage staff to encourage one another to be respectful of consumers even when rushed and work together to remedy actions that have impacted consumers at the time they occur.
* Seek regular honest staff feedback on staffing interactions, particularly after agency staff have worked.
* Provide adequate training where deficiencies are identified.

### Requirement 7(3)(c)

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

* Review and improve agency staff orientation processes to ensure there is an ability to assess that the information provided at orientation has been understood.
* Seek regular personalised feedback for consumers and staff about agency staff performance.
* Investigate thoroughly the incidents that occur whilst agency staff are used to ascertain areas for continuous improvement.

### Requirement 7(3)(d)

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

* Continue to imbed and improve training system including orientation effectiveness for agency staff.
* Look at training needs in relation to wound management, equipment usage and the provision of some personal care.

### Requirement 7(3)(e)

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

* Review, improve and embed the performance review process so that is it is used to monitor and review staff when issues or incidents occur.

### 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.
* Review organisation wide governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints. Ensure they are robust, consistent and capture consumer inputs.

### 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.
* Implement improvements for risk management systems and practices specifically in relation to wound care and falls management.
* Review and improve identifying and responding to abuse and neglect of consumers in combination with incident management.

### 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.*
* Revisit the clinical governance framework for open disclosure to ensure that it is operating in practice consistently.
* Improve and training for staff on open disclosure.