Hillview Bunyip Aged Care Inc

Performance Report

22 A'Beckett Road
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**Commission ID:** 3212

**Provider name:** Hillview Bunyip Aged Care Inc

**Site Audit date:** 1 March 2022 to 4 March 2022

**Date of Performance Report:** 19 April 2022

# Performance report prepared by

Daniela Fekonja, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 28 March 2022

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Overall consumers considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose.

Staff were observed treating consumers with respect and demonstrated understanding of individual choices and preferences. Consumers’ care planning documentation included information about their individual preferences and people important to them.

Consumers felt their values were respected by the staff and were satisfied with the care provided. Staff provided examples of how they support and respect a consumer’s individual needs. Care planning documentation reflected consumers' past life, interest and what is important to them and any developing interests.

Consumers said that they were supported to exercise their own decisions about how the care and services are delivered to meet their needs. Consumers said they are able to develop new connections and maintain existing relationships. The Assessment Team also observed that staff assisted consumers in maintaining relationships with their friends and families.

The service supports consumers to take risks to enable them to live the best lives they can. Staff described how they support consumers to take risks to live the best life they can.

Information provided by the service is current, easy to understand and enables consumers to exercise choice. Staff described how they use different methods to communicate with consumers with cognitive decline or communication difficulties.

The organisation has policies and procedures in place in relation to keeping personal information confidential. Observations of staff practice demonstrated staff respected consumers’ privacy.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 NON-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

Overall, consumers and representatives considered they were involved in care planning, including participating in ongoing assessments and planning of care. However, consumers' care plans showed inconsistencies between the consumer’s care planning, which did not align with the consumers’ current and/or changing care needs.

Care plan development is not timely following admissions and does not include a comprehensive assessment of consumers, including consideration of risks to the consumers’ health and well-being.

The Assessment Team identified approximately 50% of consumers who have not had their three-monthly care plan review over the previous three months as per the service's protocols.

The service did not adequately review the care and services for consumers who experienced a change in their care needs or circumstances. Consideration of further assessment and/or review of consumers’ care and services was not always evident following an incident.

Consumers and/or their representatives described, and care documentation reflected, their participation and that of others they wish to be involved. Management and clinical staff described how consumers, representatives, health professionals and others contribute to consumer care.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found that care plan development is not timely following admission and does not include a comprehensive assessment of consumers, including consideration of risks to the consumers’ health and well-being. The Assessment Team noted the service’s admission protocols state all care planning assessments are to be completed within 20 days of the admission.

For one consumer the Assessment Team found that a number of initial care planning assessments including assessments for physical, verbal, or wandering behaviours were not completed following their admission to the service on 16 February 2022. There was no behaviour support plan in place, nor consent obtained for the use of psychotropic medication prescribed to manage responsive behaviours. The consumer was also on fluid restrictions and weight checks every second day from 20 February 2022, but there is inconsistency with the monitoring of their fluid intake and only one weight check is recorded on 26 February 2022. The consumer was sent to hospital by the medical practitioner due to a possible fluid overload on 3 March 2022.

A further 11 consumers were on fluid restriction and the Assessment Team found that five of the 11 consumers had inconsistent fluid charting completed.

A second consumer who had an unstageable pressure injury identified on 25 December 2021 did not have a wound chart created until five days after the wound was identified. The wound chart did not consistently document the progress of the wound and did not contain any wound description. There was inconsistency in the documentation of the wound measurements.

A third consumer did not have pain charting or pain assessment following admission to the service on 13 January 2022. The consumer experienced an unwitnessed fall on 8 February 2022 and although it was noted that the consumer complained of back pain for the next two days, pain charting was not commenced. The consumer was reviewed by their medical practitioner and pain medication was prescribed on 14 February 2022.

Management stated care plans are developed from assessment results, following a consumer’s admission to the service, however, management acknowledged that this does not always get followed by the nursing staff. They were unable to provide feedback to the Assessment Team regarding the gaps identified in the documentation of sampled consumers. Care staff stated they were not aware that they needed to complete pressure area care or fluid balance charts.

The Assessment Team did not view documentation showing risk assessments for consumers under environmental restraint have been undertaken or that authorizations and informed consents are in place.

The Approved Provider stated the service’s admission protocols state all care planning assessments are to be completed within 30 days of the admission.

In relation to the first consumer, the Approved Provider stated they were admitted 12 days prior to the site audit and although assessments have been completed in the electronic system they were not marked off the Resident Admission and Assessment Schedule. This has now been updated to reflect the assessments completed. The Approved Provider states the consumer is prescribed psychotropic medication for anxiety and insomnia and is not subject to chemical restraint. Behaviour charting was not undertaken as no risk was identified on admission, behaviour charting was conducted according to the Admission and Assessment Schedule. A behaviour support plan was created on 17 March 2022 and consent was obtained for the psychotropic medication on 11 March 2022.

In relation to fluid balance charting, this is written on a whiteboard in the care office, on the handover sheet and in the consumer’s nutrition/hydration care plan. This information is then provided to care staff to instruct them as to the fluid plan for each consumer. The Approved Provider also stated that fluid balance charting is not routinely performed due to the service being considered the consumer’s home and it would not be done if they were living at home. It is done when a consumer is on food charting. The Approved Provider acknowledges the need for improvement in this process.

In relation to the second consumer, the Approved Provider provided a current skin assessment for the consumer which showed the strategies in place as noted by the Assessment Team and photographs, most with measurements taken from 22 February 2022 to 22 March 2022. The Approved Provider also stated there was a decline in documentation due to staffing being impacted by COVID-19 in January 2022.

In relation to the third consumer, the Approved Provider stated the consumer was first admitted as a respite admission and pain assessments are only conducted when pain is expressed. At the time of the fall, the consumer had been a permanent consumer for 4 days and had commenced on the resident admission assessment schedule. The Approved Provider provided a pain assessment/management plan for this consumer commencing 15 February 2022.

Although the Approved Provider supplied information that assessments are undertaken as per the admission schedule many were not conducted as per the scheduled timeframes including falls risk assessments, skin assessments and nutrition assessments. The falls risk assessment for the first consumer was done after they had a fall at the service. The Approved Provider also acknowledged that it is an area of concern and has included it in their plan for improvement.

I find this requirement Non-compliant as the service does not have effective assessment and planning tools to ensure they are identifying and addressing the needs of the consumer.

### Requirement 2(3)(b) Non-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 care assessments and planning do not reflect consumers’ current needs and are not consistently updated and reviewed when changes occur. The Assessment Team also found that although for most consumers, care documents detail their individual care needs, goals and preferences these are not always followed. The service was able to demonstrate that advance care planning is initiated during the initial assessment process and consumers and their representatives are encouraged to complete the documentation.

For one consumer their current need in relation to fluid restriction was not adequately monitored or effectively managed as per medical directives.

Another consumer’s care planning did not reflect the changes in their skin integrity, specifically, the wound charting commenced five days after the pressure injury was identified.

A third consumer’s care planning did not reflect the changes in their pain management.

For some consumers on fluid restrictions, their needs were reviewed by the local medical officer following the site audit and some had the restrictions removed.

The Approved Provider included in their plan for continuous improvement that the care plan policy will be reviewed and updated.

I find this requirement Non-compliant as although advanced care planning is completed as required, the current needs of consumers are not always reflected in planning and assessment to allow them to live as well as they can.

### 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) Non-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 was unable to demonstrate that the outcomes of assessment and planning are effectively communicated to staff.

Two consumers were unable to describe what a care plan is and did not know whether it is available for them to access.

Staff told the Assessment Team they conduct three monthly reviews, including a brief telephone call to the representative where appropriate; however, approximately 50% of the consumers have not had this conference.

A registered nurse said that while they communicate regularly with representatives, the outcomes of these conversations are not always thoroughly documented.

Staff also stated that if any family member requests to review or requires a copy of the care plan, they refer the family member to the clinical manager.

The Approved Provider supplied the resident of the day schedule and the care plan review schedule and stated they were confident all reviews occurred as per the schedule. They stated that discussions held with consumers or their representatives are documented on the care plan.

The Approved Provider has included in their action plan information to representatives via a newsletter, on what is a care plan and how it works.

I find this requirement is Non-compliant as it is not evident that the information documented in a care and services plan is effectively communicated to the consumer and is readily available to them.

### Requirement 2(3)(e) Non-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 did not adequately review the care and services for consumers who experienced a change in their care needs or circumstances. While regular reviews of care occur, these are not always effective in capturing changes in consumers’ needs.

Consideration of further assessment and/or review of consumers’ care and services was not always evident following an incident.

One consumer had two unwitnessed falls on 8 and 26 February 2022 respectively. In both cases, there was evidence of a head strike. In relation to the first fall, although the consumer complained of pain it was not charted or reviewed until 14 February 2022. In relation to the second fall, the consumer was not reviewed by a medical practitioner until they vomited and was subsequently transferred to the hospital on 27 February 2022. The care planning for this consumer was not updated to reflect their pain and a falls risk assessment was not documented. Upon return from the hospital, although staff completed a skin check identifying the consumer’s current wounds, the consumer’s care plans were not updated to reflect the wounds and pain charting was not initiated despite changes in prescribed analgesia.

A second consumer who is a high falls risk, experienced multiple falls in December 2021 and January 2022 resulting in superficial injuries. There were inconsistencies in the documented care in relation to neurological observations and medical and allied health review post-fall. This consumer did not have a pain assessment completed since July 2021. Staff stated pain charting was required to be completed following a fall to monitor a consumer’s pain. They could not explain how the protocols were not followed.

The Assessment Team stated the service has a policy that guides staff in care plan reviews both on a regular basis and following changes to care needs. Clinical indicators are reviewed monthly to identify further opportunities to improve care and clinical outcomes.

The Approved Provider stated that the Falls Management policy and the deteriorating consumer process will be reviewed and updated. The Approved Provider also stated that there is no medical attendance after hours or on weekends by local medical officers. The High-Risk policy will also be reviewed and a registered nurse will take on a risk portfolio.

There will also be further education provided to staff in relation to recognising and reporting changes in consumers’ health.

Based on the information I find this requirement Non-compliant.

# 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

The Assessment Team found that consumer files did not demonstrate that all consumers receive safe and effective personal and clinical care tailored to their individual needs, is best practice, and optimizes their health and well-being.

Pressure injuries acquired at the service were not consistently identified and treated in a timely manner, resulting in deteriorating wounds.

The service does not have an effective process to monitor, analyse and action high-impact or high prevalence risks associated with the care of each consumer. The service did not adequately demonstrate effective management of each consumer's fluid balance charts and falls.

Deterioration in consumer’s function, health or capacity is not recognised and responded to in a timely manner.

Consumers said that staff are aware of their needs and preferences, and consumers do not have to repeat information often. However, there are numerous and significant gaps in the documentation of care reviews, delivery of care, and consultation with consumers and/or their representatives.

Consumers and/or their representatives are satisfied with consumer comfort and care at the end of their life is provided, and they are provided with support.

Most consumers and/or their representatives are satisfied that referrals occur to health professionals when needed and in a timely manner.

The service has adequate infection control processes and policies and consumers and/or their representatives expressed satisfaction with the service’s approach to implementing measures to prevent the COVID-19 virus from entering the service. The organisation has an established policy and procedure in relation to antimicrobial stewardship.

The Quality Standard is assessed as Non-compliant as four 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 the service was unable to demonstrate that each consumer receives safe, effective and personalised care. The Assessment Team identified that care provided in skin integrity, pain management, and restrictive practices is not best practice or tailored to a consumer’s needs. Management at the time of the site audit acknowledged there were gaps in these areas and they would be addressed through staff education.

One consumer who experiences pain last had their pain assessment reviewed in December 2021. Strategies to manage the pain include, ‘as needed’ (PRN) analgesia and massage four times a week for 20 minutes. The analgesia was provided daily between 4 and 11 December 2021 but the pain was only documented on three occasions. The reason for the administration of the analgesia was not recorded nor was the effectiveness. Staff told the Assessment Team sometimes they do not have time to go back and check on the consumer after administering PRN analgesia. The consumer’s representative does not wish for the consumer to be prescribed strong pain medication and has communicated this to the service.

I have also considered the consumer documented in Requirement 2(3)(a) who does not currently have a pain management assessment or pain care plan.

One consumer with a pressure injury to their foot did not have the injury documented in the wound chart for five days after being identified. Measurements were not always taken of the wound and there was no description or status provided of the wound.

A second consumer did not have wound photos taken since the dressing regime commenced and no wound measurements were taken to monitor if the wound was healing or deteriorating. The wound chart did not provide information on the status of the wound.

Management told the Assessment Team some staff do not know how to upload the photos and staff said photos are only taken if the wound deteriorates.

The Assessment Team documented deficits in the management of restrictive practices which I have also considered in Requirement 3(3)(b).

Although consumers and representatives are generally satisfied with the care provided, Management acknowledged there were gaps in skin integrity, pain management, and restrictive practices. They would be implementing actions to educate staff.

In relation to the management of the pain of the second consumer the Approved Provider stated as the consumer was first admitted as a respite consumer they only had an interim care plan and when the prescribed analgesia was changed on 13 January 2022 pain charting commenced. The Approved Provider submitted evidence showing the current pain charting for this consumer.

The Approved Provider stated further education will be provided to staff in relation to the pain management.

In relation to wound management and skin integrity, the Approved Provider said there will be a review of both policies to include a description of wounds, how to take measurements and how to upload photos and the frequency in which they are taken.

Based on the information I find the requirement Non-compliant but acknowledge the Approved Provider has taken action to make improvements in these areas.

### 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 does not have an effective process to monitor, analyse, and action high-impact or high prevalence risks associated with the care of each consumer. The service did not adequately demonstrate effective management of each consumer’s care relating to restrictive practices, fluid balance charts and falls.

The Assessment Team documented under Requirement 3(3)(a) that the consumer’s residing in the memory support unit are under environmental restraint in the form of a keypad lock to the doors. Two consumers residing in the unit do not have informed consent for the use of the restraint and no reason for its use is recorded as being required. The representative of one of the consumers stated they have not been asked to consent to the use of the environmental restraint.

Another resident had a mechanical restraint in the form of a bed stick to assist with mobility in bed and had appropriate risk assessments, restraint authorisation, consent, and reviews in their documentation to monitor the ongoing risk of using the restraint. However, the daily checklist to ensure safe use of the bed stick was not completed consistently by staff.

The review of care planning documentation of consumers prescribed psychotropic medications identified the process for assessment and monitoring, but the review did not occur according to regulatory requirements. Documentation showed that a behaviour support plan had not been completed for a consumer receiving ‘as required’ PRN psychotropic medication to manage their behaviour. Informed consent has not been obtained from the substitute decision-maker. Staff are unaware of what interventions or strategies are in place to effectively manage the consumer’s behaviours.

Neurological observations were not completed consistently for two consumers who had suffered unwitnessed falls. The falls risk assessment (FRAT) and review by a medical practitioner did not occur on two occasions. Staff could not demonstrate a correct protocol for the timing of neurological observations following an unwitnessed fall in line with the service’s fall prevention and management policy.

As discussed in requirement 2(3)(a) fluid restriction has not been managed or monitored effectively for a number of consumers. One consumer on medication to manage fluid build-up due to pitting oedema was hospitalised due to fluid detected on the lungs.

Another consumer on 1.5 litres a day fluid restriction was allowed to have a jug of water in their room which they said staff assisted to fill up when empty.

Adequate diabetes and catheter care were provided to consumers with these requirements.

In response, the Approved Provider stated only two consumers were under environmental restraint and the others were in the memory support unit as they thrive in a quieter environment. The representative named is not the substitute decision-maker and therefore was not asked to provide consent. It is accepted that informed consent is required and included in their action plan. Risk assessment and behaviour support plans were completed for these consumers.

The Approved Provider does not consider the consumer to be under chemical restraint as they are prescribed ‘as needed’ psychotropic medication for insomnia and restlessness overnight. It is documented why it is required, what alternatives are used and the effectiveness when administered. A behaviour support plan was created on 17 March 2022 after review by the registered nurse and local medical officer. This was completed after the site audit had been conducted.

The Approved Provider acknowledged there are gaps in falls management, fluid management and restrictive practices and has included the improvements to be made as part of their continuous improvement plan. This includes a review of policies and further education for staff.

Based on the information I find this requirement Non-compliant.

### 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) Non-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.*

The Assessment Team found the service did not effectively respond to the deterioration in one consumer’s health and well-being.

Staff documented the consumer had pain around the right heel area on 25 December 2021 but the consumer was not reviewed nor their pain assessed until 27 December 2021 with no follow-up. Progress notes indicate that staff reviewed the right heel again on 30 December 2021 and documented “unstageable pressure injury on the right heel and stage two on sacrum”. The wound chart was commenced on the same day.

The skin assessment was not reviewed until 3 January 2022 and interventions including heel elevator for heels and ROHO cushion for the sacral area were documented for the consumer. The heel elevator being used to alleviate pressure from both heels was ceased due to poor use by staff. The medical practitioner reviewed the consumer on 11 February 2022 as on 6 February 2022 the consumer was found to have an offensive smell coming from the wound. The service did not refer the consumer to a specialist wound consultant as management stated at the time of the site audit, they had a nurse who has done an extensive course on wound management and attends to wounds regularly.

Pain was not consistently or adequately assessed and the location of the pain was not recorded on the pain chart. The consumer was in pain during a dressing change but there was no information recorded as to how that pain was managed. The representative was not informed of the deterioration of the wound but was informed when it was identified and when it was reviewed by the medical practitioner.

The service has a range of policies and procedures, including the assessment of clinical deterioration that guides staff in the assessment, monitoring, and reporting process, however, staff had not adhered to this in the care of this consumer.

The Approved Provider has included a review of the policy and process for deteriorating consumers in their action plan.

Based on the information provided I find the requirement is Non-compliant.

### 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 identified numerous and significant gaps in the documentation of care reviews, delivery of care, and consultation with consumers and/or their representatives.

One consumer’s fluid restriction was not consistently charted and staff were unaware that the consumer was on fluid restriction for a medical reason.

Another consumer’s pain was not reviewed when staff observed a pressure injury nor when the consumer complained of pain during a dressing change. Clinical staff stated they did refer the consumer for medical practitioner review, however, nil documentation was completed.

Clinical staff described how there is a handover prior to each shift and described that sometimes information gets missed from shift to shift. The Assessment Team observed care staff carrying a handover sheet that was updated five days ago and when questioned care staff stated that “information usually remains same for few days”.

The Approved Provider acknowledged there are gaps in the process and has included improvements in the action plan to ensure handover sheets are updated daily and printed daily.

Based on the information I find the requirement Non-compliant

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Overall consumers considered 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.

Consumers feel supported to do the things they want to do and are satisfied with the range of activities on offer, as well as their individual preferences as to whether they choose to participate. Care planning guides staff with the level of support consumers may need to attend activities such as physical assistance and reminders of the type and location of planned activities.

Emotional, spiritual and psychological wellbeing was promoted at the service. Staff described ways they identified and assisted consumers when they felt low. Care planning documentation included information on emotional, spiritual and psychological needs and preferences.

Consumers are satisfied that the service supports and enables them to participate in the wider community, maintain important relationships, and pursue their interests. Care planning documentation for consumers sampled incorporates assessments and the life story of the consumer consistent with their needs. Activity records show consumers attend a range of activities both within and externally to the service. Evaluation of consumer needs occurs regularly and consumers raise any issues during the resident meetings.

Consumer feedback, care plan documentation and staff feedback demonstrate there is a process in place to ensure that information about consumers’ conditions, needs and preferences are communicated within the service and with others responsible for consumer care and services. Nutrition and hydration care plans detail consumers’ needs and preferences regarding food.

Care planning documentation show referrals and support provided by individuals and organisations for consumer participation and wellbeing. Lifestyle staff described links with a range of community groups to enhance consumer experiences.

Consumers provided mixed feedback on the quantity, quality and variety of food provided. However, consumers stated they receive enough food and do not get hungry and there are alternatives available. Care planning documentation includes consumer needs, preferences, likes and dislikes as well as special requirements such as consumers requiring modified textured diets.

Consumers and staff are satisfied they have access to suitable and well-maintained equipment. Equipment was observed to be clean, well-maintained and available to meet the needs of consumers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment.

The service is welcoming and offers a range of communal spaces that optimise consumer engagement and interaction. The service was observed to be clean and uncluttered enabling the free movement of the consumers.

The Assessment Team observed the internal areas of the service to be safe, clean and well maintained. Consumers reported that the service environment is comfortable and clean. The Assessment Team observed the courtyards and specifically the internal courtyard of the memory support unit to be unkempt. The Assessment Team observed spider webs on all external areas of the service and bird droppings on external chairs and tables. The maintenance officer left in mid-2021 and management has struggled to employ a replacement. The Assessment Team identified this caused little impact on consumers’ enjoyment of the service.

The external gardens at the service were being cleaned and tidied during the site audit by members of the local community group.

Consumers’ rooms were decorated with personalised items and furniture and blankets. The new wing of the service has ‘memory boxes’ located outside of the consumers’ rooms where items of personal importance are on display.

Consumers said that the furniture, fittings and equipment at the service were clean and well maintained. Staff and consumers said maintenance staff were prompt and responsive to their requests.

Staff conduct regularly scheduled audits of consumers’ rooms. Items assessed as part of the rooms audits include ensuring items are not placed too close to heaters, electrical cabling does not pose a tripping hazard and cables are not frayed and the call bell systems are functional.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers considered that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Most consumers and representatives were satisfied management is very responsive at the service and any issues raised have been responded to satisfactorily and within sufficient timeframes.

The service demonstrated that there are multiple avenues for consumers to raise feedback and make complaints and for those that need support to provide feedback this is facilitated. All consumers and representatives interviewed by the Assessment Team felt comfortable raising a complaint or concern via the feedback forms or directly with staff and management.

Consumers were satisfied they had been made aware of and understood how to access advocates or language services if they wished to raise a concern. Care staff explained the various means available to assist consumers with cognitive impairment or language barriers to submit feedback and were able to provide information about advocacy services. The Assessment Team observed advocacy and feedback information displayed throughout the service.

Most consumers and representatives are satisfied with the action taken in relation to complaints and how staff and management acknowledge mistakes made and apologise if things go wrong. Staff were able to describe the process of open disclosure and have received education in relation to this. Policies and procedures reviewed in relation to open disclosure reflected this process.

Management described how complaints data trends are reviewed and how action is taken to improve the quality of care and services. Complaints documentation reviewed identified appropriate action taken by management.

Feedback from consumers at the service resulted in improvements to the living environment and lifestyle areas. For example:

* + A new automatic door was installed to improve access to the internal courtyard for residents with impaired mobility.
	+ Raised planters were built to ensure consumers could participate in gardening activities.
	+ More computer stations were purchased for care staff to access care plans and enter progress notes.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 NON-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

Overall consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. The Assessment Team observed positive and respectful interactions between staff and consumers.

Although management demonstrated policies and procedures provide guidance to enable the workforce to deliver the care outcomes required by the standards, the Assessment Team identified this is not consistently followed by care staff. Management acknowledges that there are gaps within existing training and that processes are not consistently followed.

Although performance appraisals and monitoring of staff performance are said to occur, this has not resulted in the identification of the lack of knowledge identified by the Assessment Team and as acknowledged by the Approved provider in other Requirements.

The service demonstrated the workforce is planned to ensure a suitable mix of skills and staff numbers in various roles to enable the delivery of safe and effective care and services. A review of the rosters demonstrated that shifts are covered, and call bell audits illustrated a timely response to calls.

Consumers and representatives expressed satisfaction with how care needs were met and were confident staff were adequately trained. Care staff are recruited to specific roles with designated responsibilities. The responsibilities, general duties and key performance indicators for each role are outlined in employee position descriptions reviewed by the Assessment Team.

Core competencies are maintained through annual online and in-person education. Annual core competencies assessed at the service included: manual handling, fire safety, responding to elder abuse, infection control and responding to dementia and challenging behaviours.

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

## Assessment of Standard 7 Requirements

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

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

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

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

### Requirement 7(3)(c) Compliant

*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.*

Staff did not consistently demonstrate appropriate knowledge and skills relating to consumers’ care needs and requirements. The Assessment Team identified that skin integrity, pain management, fluid intake and restrictive practices are not effectively documented and managed at the service as per established policies.

Although management demonstrated policies and procedures provide guidance to enable the workforce to deliver the care outcomes required by the standards, the Assessment Team identified this is not consistently followed by care staff. Management acknowledges that there are gaps within existing training and that processes are not consistently followed.

For one consumer with an unstageable pressure wound, wound documentation and photographs were inconsistent in measurement and description and some staff were unsure how to upload photos onto the skin assessment in the electronic system. In regard to pain charting for the same consumer, there was insufficient documentation as to why analgesia was administered and no evidence it was assessed for effectiveness.

There were also deficiencies in the monitoring of consumers under fluid restriction in accordance with medical advice.

Management acknowledged gaps in their skin integrity, pain management, and restrictive practices. Management explained additional education was required to ensure staff follow best practice procedures and existing policy.

Four care staff stated that new staff at the service, with less experience, had poor time management and initiative when performing their roles which management acknowledge at the time of the site audit. They blamed the situation on staff completing qualifications online with minimal practical experience due to COVID-19. In response to this feedback, the service created increased supervisor and buddy shifts for all new starters and provide any feedback directly to staff as part of probationary performance meetings.

Staff said management encouraged and acted on feedback about training and was supportive of requests for additional training. Staff were confident that, where required, additional training could be requested directly with management, via feedback forms or during performance appraisals.

The service maintains records of staff attendance and completion of mandatory training. Management described how monitoring systems prompt staff to complete mandatory training.

The Approved Provider has included in their action plan a commitment to ensuring there is increased staff supervision for new staff. They will provide feedback as part of the six month probation period. They will develop a Care Handbook and outline duties and the expectation on how duties are to be completed.

Based on the information I find this requirement Non-compliant.

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

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

Although the Assessment Team found this requirement met I have come to a different view.

Management confirmed to the Assessment Team that annual performance appraisals are conducted with all staff and this is an opportunity to discuss training and development goals for the coming year. A range of processes is used at the service to monitor staff performance including monitoring incidents, observations and surveys as well as feedback from consumers, registered nurses and care staff.

Although staff do receive regular performance appraisals, based on the deficits outlined in previous requirements these reviews failed to ascertain areas where staff lacked knowledge. The issues identified by the Assessment Team in relation to deficits in assessment and planning and the provision of clinical care under Quality Standards 2 and 3 indicate that staff performance is not assessed, monitored and reviewed effectively.

The Approved Provider has also acknowledged the deficits in Requirement 7(3)(d) and that staff required extra training. It is reasonable to expect this should have been identified in staff performance reviews or during probation including where buddy shifts were being conducted.

I find this requirement Non-compliant as the performance reviews and monitoring have failed to ascertain that staff required further training in a number of areas.

# 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

Most consumers considered that the organisation is well run and that they can partner in improving the delivery of care and services.

The service does not demonstrate effective risk management systems to monitor high-impact or high-prevalence risks such as the early identification of pressure injuries. The service demonstrated, however, that systems and practices are in place to effectively identify and respond to the abuse and neglect of consumers and to support consumers to live the best life they can.

The service demonstrated consumers and representatives are involved in the development, delivery and evaluation of care and services. Management seeks input from consumers and representatives through participation in consumer forums, surveys and individual conversations. The service maintains a continuous improvement register to record and action improvement ideas.

The service has a draft clinical governance framework that management stated is not fully embedded into policies and procedures. The service was unable to demonstrate how they effectively monitor consumers’ prescribed psychotropic medications that are considered chemical restraint.

The service is managed by a Board that oversees monthly commentary reports relating to incident data, audits, complaints and feedback, financial expenditure, and continuous improvement.

The service conducts internal auditing covering all aspects of the Aged Care Quality Standards. Management said through this process they identify trends and deficiencies which are reviewed at management meetings and at a Board level. Actions taken to address identified deficiencies are monitored and reviewed by the Board for effectiveness and to identify changes required to policies or procedures.

The service demonstrated the governance systems that are in place and their application in considering the best outcomes for consumers. The board monitors and reviews routine reporting and analysis of data related to the consumer experience. The board then satisfies itself that systems and processes are in place to ensure the right care is being provided in accordance with the Aged Care Quality Standards.

The Quality Standard is assessed as Non-compliant as two 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.*

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

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

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

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

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

### 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 identified that the service does not have an effective process to monitor, analyse, and manage high-impact or high prevalence risks associated with the care of each consumer. In particular, the service did not adequately demonstrate effective management of pressure injuries, fluid intake, the use of mechanical restraints and falls for each consumer. Although management and clinical staff were able to describe how they aim to monitor these risks the documentation reviewed by the Assessment Team did not demonstrate these actions are consistently performed.

Management acknowledged gaps in skin integrity, and restrictive practices and notified the Assessment Team that they would be implementing actions to educate staff.

The Approved Provider stated these deficits would be addressed in their continuous improvement action plan which includes a review of the wound policy and education for staff.

Based on the information I find this requirement Non-compliant.

### 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.*

Management and clinical staff were unable to demonstrate to the Assessment Team how they effectively monitor consumers’ prescribed psychotropic medications that are considered chemical restraint. Although the service has policies for minimising the use of restraint, including chemical and environmental restraint, management and clinical staff were unable to demonstrate this was consistently applied.

The service has a draft clinical governance framework that management stated is not fully embedded into policies and procedures. The service also has policies relating to antimicrobial stewardship, minimising the use of restraint and an open disclosure policy.

One consumer is prescribed psychotropic medication as required for the medical condition of insomnia and for restlessness overnight. However, it is also documented as being used for agitation. While I acknowledge the consumer now has a signed informed consent form and behaviour support plan, this was not in place at the time of the site audit.

The Assessment Team did not view risk assessments or signed informed consent forms for consumers residing in the memory support unit who were subject to environmental/perimeter restraint.

They did not view documentation showing an approved health practitioner has assessed and documented the reason for the restraint or regular reviews by health professionals of the need for the restraint with records of the outcome of these reviews.

The Approved Provider’s documentation shows that risk assessments and informed consent forms were obtained for the consumers. The Approved Provider information indicates that consumers with cognitive deficits are not subjected to environmental restraint, but they have still obtained consent and created behaviour support plans.

I find the requirement is Non-compliant as at the time of the site audit there were inconsistencies in the management of restrictive practices and the clinical governance framework is not fully embedded in staff practice.

# Areas for improvement

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

* Ensure assessment and care planning includes consideration for relevant consumer risks, particularly in relation to wound care, fluid management and restrictive practices and reflect current needs.
* Ensure consumers’ care and services are reviewed when their circumstances change or incidents impact their needs and goals.
* Ensure staff complete all required documentation in relation to monitoring and review of consumers in relation to fluid restriction and wound care.
* Introduce internal processes to monitor the accuracy of consumers’ assessment, care planning and review documentation.
* Ensure consumers and representatives are aware of and can readily access their care plans.
* Ensure consumers receive appropriate personal and clinical care tailored to their individual care needs, particularly in relation to skin integrity, wound care, pain management and fluid restriction management.
* Ensure all consumers who require restrictive practices, including chemical restraint, are assessed, have records of informed consent, and are monitored and reviewed as required.
* Introduce internal processes to monitor the provision of consumer clinical care particular in relation to skin integrity, wound care, pain management, and the use of restrictive practice.
* Ensure all staff have access to current handover information that identifies each consumer’s key risks and other relevant care information.
* Provide staff training and support in relation to consumers’ clinical assessment, care planning, monitoring and review including related documentation.
* Provide staff training and support in the management of consumers’ skin integrity, wounds, pain fluid restriction and restrictive practices.
* Ensure performance appraisals are comprehensive and capture all development needs and training requirements.
* Complete the comprehensive review of restrictive practices used at the service and ensure their use meets legislative requirements.
* Ensure the new clinical governance framework is fully embedded in staff practice.