IBIS Care Miranda

Performance Report

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**Commission ID:** 0034

**Provider name:** IBIS (No 2) Pty Ltd

**Site Audit date:** 11 April 2022 to 13 April 2022

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

# Performance report prepared by

Kathryn Spurrell, 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** | **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) | 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** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-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** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | 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 3 May 2022.
* other information and intelligence held by the Commission in relation to the service.

# 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

Consumers and representatives confirmed they were treated with dignity and respect, with their identity, culture and diversity valued. Staff spoke of consumers in a respectful manner and demonstrated a shared understanding of consumer’s identity, culture and diversity. Care planning documentation included information on the consumer’s life history, cultural identity and cultural practices.

Consumers and representatives considered staff understood their culture and diversity and provided examples of how staff assisted them to participate in cultural activities. The Assessment Team observed consumers’ rooms had been personalised and included artwork that reflected their diverse cultural backgrounds. Staff were able to describe how consumers’ culture and diversity influenced the delivery of care and services.

Consumers were satisfied that they were supported to exercise choice and independence, had the ability to make their own decisions and maintain personal relationships. Staff were able to describe the consumers with family members also residing within the service and demonstrated an understanding of how the service encourages the consumers to maintain these relationships. The Assessment Team observed the service’s education topics and policies to include information on encouraging consumers to discuss care and services and identify who they prefer to make decisions for them and be involved in their care.

Care planning documentation evidenced the completion of risk assessments in consultation with allied health professionals and consumers. Consumers confirmed the service supports them to life they choose and engage in activities that are important to them. Staff demonstrated an awareness of activities that included an element of risk to consumers and could describe the strategies in place to mitigate these risks. For example, staff outlined a consumer’s choice to smoke and the steps taken to reduce risk, which included, supervision, provision of a smoking apron and the explanation of the associated risks.

Consumers and representatives indicated they received information that is current, accurate and timely, and communicated clearly, easy to understand and enabled them to exercise choice and control. Staff indicated that upcoming activities were communicated to consumers via the weekly activities calendar and verbally through regular updates and conversations with consumers. The Assessment Team observed the weekly activity schedule and monthly newsletter on display within the service.

Consumers expressed the service was considerate of their personal privacy and confidentiality of their personal information. Staff described the practical ways they respect the privacy of consumers, such as knocking on consumers’ doors prior to entering and keeping doors closed when providing personal care. The Assessment Team noted the service’s orientation program included privacy and dignity training.

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 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The service demonstrated assessment and care planning processes that were implemented to inform the delivery of safe and effective care and services. Consumers and representatives expressed satisfaction with the service’s assessment and planning process. Staff were aware of the relevant risks to the health and well-being of each consumer and the strategies in place to ensure the safe and effective delivery of care. Care planning documentation was individualised and included specific risks to each consumer’s health and well-being such as falls, pain, skin integrity and risk of choking.

Care planning documentation evidenced that consumers and representatives were consulted throughout assessment and care planning, including advanced care and end of life planning. Consumers and representatives confirmed the service had discussed end of life planning with them and felt comfortable to approach staff or management to discuss further if needed. Staff demonstrated a shared understanding of the needs, goals and preferences of consumers and were aware of their end of life wishes.

Consumers and representatives said they were consulted throughout assessment and care planning, and when required, input was sought from health care professionals. Care planning documentation evidenced an ongoing partnership with the consumer and others that the consumer wishes to be involved in their care. Staff outlined the process for referrals to external allied health professionals and advised that any changes to the care needs of consumers identified by external parties was communicated internally during staff handovers.

Consumers and representatives confirmed the outcomes of assessment and planning had been communicated to them and they were able to access consumer care plans upon request. A review of case conferences by the Assessment Team evidenced care plan consultation with consumers and representatives. Staff advised that consumers are consulted throughout the assessment and review process if are cognitively able to be involved, in the event a consumer is unable to be involved, their representative is included. Consumers and representatives indicated that consumer’s care and services are reviewed on a regular basis, or when the consumer’s circumstances have changed.

Staff outlined that care plans were reviewed every three months and that they were aware of the incident reporting process and how and when these incidents prompt a review of consumer care needs. Care planning documentation evidenced most care plans were reviewed within the three-month timeframe, however the Assessment Team noted that care plans for two consumers were outdated. The Assessment Team raised this with management who advised that they have reviewed assessments for these consumers during the Site Audit following feedback from the Assessment Team and noted that there were no significant changes from the last review and provided evidence of this to the Assessment Team. ‎

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.*

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Consumers and representatives confirmed the consumer’s end-of-life wishes were discussed with them and were confident the service would support their needs and preferences. Care planning documentation for a recently deceased consumer evidenced an advance health directive and end of life plan were in place. A review of progress notes outlined staff were monitoring for signs of pain and distress and that the service had followed the consumer’s wishes. Staff could describe the way care delivery changes for consumers nearing end of life and practical ways in which a consumer’s comfort is maximised.

Deterioration or changes in a consumer’s health is recognised and responded to in a timely manner, as confirmed by care planning documents reviewed by the Assessment Team. Staff were able to describe their roles and responsibilities in identifying and reporting changes or deteriorations in consumer’s health. Consumers and representatives indicated that the service responds appropriately to deteriorations in consumer’s health and refers consumers to external providers as required. A review of clinical records by the Assessment Team demonstrated consumers are regularly monitored by staff and if deterioration or change of a consumer’s mental, cognitive or physical function, capacity or condition occurs, this is recognised and responded to in a timely manner and representatives are notified. ‎

Consumers and representatives stated that their condition, needs and preferences are well communicated throughout the service and external health care professionals. Staff described the various ways information about the consumer’s condition is communicated and advised they access to consumer files to ensure appropriate care needs are attended to. The Assessment Team observed shift handover and staff communicating any changes to consumer’s care needs and preferences.

Consumers and representatives confirmed they were satisfied that referrals to health professionals occurred in a timely manner and consumers have access to relevant external health professionals when required. Staff advised that referrals are made in consultation with the consumer and representative and consent is obtained prior to referrals being made. The Assessment Team observed referrals to allied health professionals such as the physiotherapist, podiatrist and other health professionals.

The service had documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. Staff advised they have received education and training in relation to infection control and COVID-19, including handwashing, sneeze and cough etiquette and the correct use of personal protective equipment. Consumers and representatives advised the service’s communication and infection control practices regarding the management of COVID-19 were well coordinated and managed.

The Assessment Team found the service did not meet Requirement (3)(a) regarding the delivery of safe and effective care for each consumer, and Requirement (3)(b) regarding the effective management of high impact or high prevalence risks associated with the care of each consumer. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-compliant. I have provided reasons for the finding in the relevant requirement below.

The Quality Standard is assessed as Non-compliant as two 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 identified that the service was unable to consistently demonstrate that each consumer received safe and effective clinical care that is best practice, tailored to their needs and optimised their health and well-being. Summarised relevant evidence relating to safe and effective personal and clinical care included:

* Management initially indicated to the Assessment Team that there were no consumers subject to environmental restraints, however the Assessment Team later identified there were sixteen consumers that were restricted from leaving the service or entering certain areas of the service as they present risks to themselves or others. The Assessment Team found that none of these consumers had any environmental restraint authorisation assessments conducted that detailed the behaviours of concern, alternative strategies trialled, authorisation from a medical practitioner and informed consent by the consumer or representative.
* Management initially indicated to the Assessment Team that there were two consumers subject to chemical restraints, however the Assessment Team identified an additional two consumers that received ‘as needed’ psychotropic medication. The Assessment Team noted that three out of the four consumers subject to chemical restraint did not have chemical restraint authorisation assessments in place which details the behaviours of concern, alternative strategies trialled, or informed consent by the representative for use of chemical restraint. The Assessment Team did note Behaviour Support Plans (BSP) for these consumers.
* Management initially indicated to the Assessment Team that there were no consumers subject to mechanical restraints, however the Assessment Team identified two consumers subject to mechanical restraints, including low beds.
* Staff were unable to demonstrate a common understanding of the different types of restrictive practices and what constitutes a restrictive practice.
* The Assessment Team raised the above issues with management during the Site Audit, management advised they would endeavour to contact the representatives of those consumers subject to environmental restraint to gather consent. Furthermore, management also provided evidence of completion of the chemical restraint authorisation assessments for the two additional consumers identified during the Site Audit to be subject to chemical restraint.

The Approved Provider’s written response, received 3 May 2022, outlined the actions taken and prospective actions within their continuous improvement plan, these included:

* Providing training and education to staff regarding restrictive practices.
* Gathering environmental restraint authorisation from the representatives of those consumers that are subject to environmental restraint. In addition, the doors within the service that lead to other areas in the facility and outside will be unlocked during business hours.
* Updating the Commission’s Perimeter Restraint Self-assessment tool to include definition of the areas consumers can access freely within and outside of the service. Consumers that are not restrained will be provided a swipe card and passcodes to access the locked indoor/outdoor areas.
* Gathering chemical restraint authorisation from the representatives of those additional consumers identified by the Assessment Team that are subject to chemical restraint. In addition, a review of the Psychotropic Management and Consent forms to ensure information is accurate.
* The implementation of alternative strategies prior to the use of chemical restraints and the inclusion of this information on care planning documentation.
* The completion of mechanical restraint authorisation forms for those consumers that are subject to mechanical restraint. In addition, a physiotherapist will review these consumers and their risk assessment will be updated.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues surrounding the identification of restrictive practices, at the time of the Site Audit, the service did not demonstrate that each consumer received safe and effective clinical and personal care that is best practice, tailored to their needs and optimised their health and well-being. I therefore find this Requirement Non-compliant.

### 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 identified that the service did not consistently demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer. Summarised relevant evidence included:

* A named consumer with care planning documentation that outlined rapid weight loss. Following the significant weight loss, an incident report was created and reported to management. However, there is no evidenced actions or strategies taken to manage or minimise further weight loss. In addition, the consumer’s dietary assessment was recently reviewed, but did not reference the weight loss.
* The Assessment Team raised the above issues with management during the Site Audit, management advised that following the above findings raised, they requested for an urgent dietitian review for the consumer.

The Approved Provider’s written response, received 3 May 2022, outlined the actions taken and prospective actions within their continuous improvement plan, these included:

* The implementation of immediate actions such as regular food and weight monitoring, referral to dietician and review by a doctor.
* Monitoring nutrition and hydration status and provision of preferred food and drink options, which include fortified meals.
* A case conference with consumer and their family to ensure care needs are being met.
* Staff education on weight loss management.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the immediate action taken by the Approved Provider to address the issues identified by the Assessment Team, at the time of the Site Audit, the service did not demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer. I therefore 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) Compliant

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Consumers and representatives felt that consumers received safe and effective services and supports for daily living that met their needs, goals and preferences and optimise their independence, health, well-being and quality of life. Care planning documentation outlined the services and supports consumers require to help assist them in participating in activities of interest to them. The Assessment Team observed consumers engaging in a variety of activities throughout the service.

Consumers and representatives expressed that the service provided support for daily living to promote the emotional, spiritual and psychological well-being for each consumer. Care planning documentation included information and strategies to support the emotional, spiritual and psychological well-being of consumers. Staff outlined how they identify when a consumer is feeling low and required additional support, and how they would escalate this issue to a registered nurse. The Assessment Team observed a religious service taking place within the recreational room.

Care planning documentation included information about the interests of consumers and detailed the supports that assisted consumers to participate in their community, within and outside of the organisation's service environment, maintain social and personal relationships and do the things of interest to them. Consumers described the activities they enjoy and how the service assists to facilitate and organise these activities. The Assessment Team observed staff encouraging, assisting and supporting consumers during activities.

Consumers and representatives reported that information about their daily living choices and preferences is effectively communicated throughout the service, and staff understand their needs and preferences. Care planning documentation included information to support the delivery of effective supports for daily living. Staff described how the needs and preferences are documented, updated and communicated throughout the service to ensure consistency of care. The Assessment Team observed a shift handover, it was evident that staff were communicating relevant updates and changes in consumer condition.

Consumers and representatives were satisfied that consumers receive timely and appropriate referrals to individuals’ other organisations and providers of other care and services. Care planning documents evidence the involvement of external providers of care in the provision of lifestyle supports for consumers. The Assessment Team observed a variety of brochures available to support referral to external organisations as required, including mental health organisations and translation services.

Consumers and representatives generally expressed positive feedback regarding the quality and quantity of the meals provided by the service. Care planning documentation evidenced the identification of dietary requirements and preferences to inform the delivery of safe eating practices. Kitchen staff demonstrated a shared understanding of consumer’s dietary requirements and meal preferences.

The Assessment Team observed that where equipment is provided, it is safe, suitable, clean and well maintained. Consumers indicated they had access to equipment such as mobility aids, shower chairs and manual handling equipment, and felt the equipment was safe and well maintained. Staff expressed they have access to the required equipment and that equipment issues are resolved in a timely manner by maintenance staff.

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 NON-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 and representatives expressed the service was welcoming, easy to understand and homely. The Assessment Team observed the service environment to be welcoming and the rooms of consumers to be personalised with photographs and decorations. Signage was utilised throughout the service environment to identify areas of importance and room numbers clearly visible on each of the doors.

Consumers were satisfied that the fittings and equipment are safe, clean, well maintained and suitable for their use. The Assessment Team observed cleaning staff performing a daily clean of the rooms of consumers and common areas. Management and staff outlined that maintenance requests are placed into the electronic care system and are written in the maintenance log book or communicated verbally by staff or the consumers themselves.

The Assessment Team found the service did not meet Requirement (3)(b) regarding the service environment enabling consumers to move freely, both indoors and outdoors. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint. I have provided reasons for the finding in the relevant requirement below.

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) 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) Non-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 identified that the service was unable to demonstrate that the service environment enabled consumers to move freely, both indoors and outdoors. Summarised relevant evidence included:

* The Assessment Team observed many doors that led to shared outdoor areas to be padlocked and requiring a code. In most areas, the code was required to allow access back into the facility.
* The Assessment Team observed multiple pathways and access points in the outdoor environment to be blocked by a barricade or locked gate.
* Consumers not subject to environment restraints were observed to be without codes and unable to freely move between indoor and outdoor areas.
* A consumer was observed standing at one of the locked doors asking the staff how they are able to exit.
* Multiple named consumers informed the Assessment Team they did not know how to independently navigate through the locked doors within the service.
* The Assessment Team raised the above issues with management during the Site Audit, management advised they would aim to provide means of access for all consumers.

The Approved Provider’s written response, received 3 May 2022, outlined the actions taken and prospective actions within their continuous improvement plan, these included:

* An audit to be completed to identify which consumers have swipe card access to locked doors.
* Updating the Commission’s Perimeter Restraint Self-assessment tool to identify those consumers that are restrained and those that are not, and providing this information to staff.
* Communicate information regarding accessible areas to consumers during the resident meetings.
* A review of inaccurate care planning documentation as identified by the Assessment Team.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues surrounding free movement within the service, at the time of the Site Audit, the service did not demonstrate that the service enabled consumers to move freely, both indoors and outdoors. I therefore find this requirement Non-compliant.

### 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 and representatives outlined they received information relating to the complaints and feedback processes, and that these processes are reinforced at consumer meetings. Management advised of the various strategies’ consumers are encouraged and supported to make a complaint and provide feedback, and how consumers are involved in the implementation and evaluation process once an improvement is made. The Assessment Team reviewed consumer meeting minutes to contain detailed records of consumer complaints and the efforts undertaken by management to resolve the identified issues.

Consumers and representatives were aware of external translation, advocacy and complaint mechanisms, however they indicated they are comfortable with raising concerns directly with staff and management. The Assessment Team noted that feedback forms, posters for raising complaints externally with the Commission and brochures for advocates and language services were displayed and readily available in the communal area of the service. Staff demonstrated an understanding of how to access interpreter and advocacy services on behalf of consumers.

The service demonstrated appropriate action is taken in response to complaints and open disclosure process is used when things go wrong. Staff indicated they have received training on open disclosure and demonstrated a shared understanding of the principles of open disclosure, including providing an apology to the impacted consumer, and implementing actions to prevent reoccurrence of the incident or complaint. Consumers and representatives advised they were satisfied that appropriate action is taken in response to complaints and feedback.

Management indicated that continuous improvements from consumers are collected from consumers and representatives through feedback forms, residents’ meetings, audits and consumer surveys. Consumers provided examples of the improvements within the service that occurred as result of feedback and complaints procedures. The Assessment Team noted the consumer handbook outlines that the service seeks feedback through satisfaction surveys.

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 COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Consumers and representatives were satisfied that the workforce was planned to enable the delivery and management of safe and quality care and services. Staff and management confirmed that staffing levels were sufficient to respond to calls for assistance within a timely manner and that management are on-call during the overnight shift. A review of call bell data by the Assessment team indicated the majority of call bells are responded to within the service’s ten-minute response. Management advised that all instances of lengthy response times are investigated.

The Assessment Team observed staff interacting with consumers in a kind, caring and respectful manner. Staff were observed treating consumers with dignity and respect and greeting and interacting with them in a familiar and friendly manner, calling them by their first name. Consumers and representatives confirmed staff are kind and respectful when providing care services.

Staff expressed they receive adequate training and support to perform their roles and outlined the various recently completed training modules. The Assessment Team noted that all staff, excluding those on extended leave, had completed the mandatory online training on restrictive practices. Management outlined the various ways they support staff to ensure they receive the appropriate training to perform their duties, such as, through the online training portal and through frequent toolbox training that address any identified trends within the service.

Management advised that staff performance is monitored through formal performance appraisals and informal monitoring and review. A performance appraisal includes a self-assessment of the staff’s performance and then the provision of feedback by management. A review of staff appraisals by the Assessment Team evidenced that the occurrence of appraisals is consistent with the description provided by management.

The Assessment Team found the service did not meet Requirement (3)(c) regarding the competency of the members of the workforce to effectively perform their roles. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service compliant. I have provided reasons for the finding in the relevant requirement below.

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

The Assessment Team found the service did not meet this requirement regarding the members of the workforce being competent and having the qualifications and knowledge to effectively perform their roles. Summarised relevant evidence included:

* Staff were unable to demonstrate a common understanding of the different types of restrictive practices and what constitutes a restrictive practice.
* Management provided incorrect details regarding the amount of consumers subject to chemical, environmental and mechanical restraints.
* The Assessment Team found that several consumers subject to restrictive practices, did not have the appropriate documentation in place.
* These issues have been discussed further under Requirement 3(3)(a).

The Assessment Team spoke to consumers who reported feeling confident that staff were suitably skilled to meet their care needs and also brought forward evidence that the service had effective processes for the monitoring and development of staff to ensure they were knowledgeable and effective in their roles.

The Approved Provider’s written response, received 3 May 2022, outlined the completed and prospective actions within their continuous improvement plan, these included:

* Providing training and education to staff regarding restrictive practices.
* A review of inaccurate care planning documentation as identified by the Assessment Team.
* Gathering consent from consumers and representatives regarding the use of restrictive practices.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge there have been knowledge gaps in staff, I am not satisfied that the evidence brought forward demonstrates deficits in the competence of the workforce under this requirement. Therefore, I find the service Compliant with this requirement.

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

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

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Consumers and representatives confirmed they were engaged in the development, delivery and evaluation of care and services. Management advised that consumer feedback is sought through formal processes such as audits, residents’ meetings and feedback forms, as well as informal conversations. Lifestyle staff indicated that the activities at the service were determined by the feedback provided by consumers.

The organisation’s governing body promoted a culture of safe, inclusive and quality care and services and took accountability for their delivery through a range of central policies and procedures. Management advised there is a robust organisational structure that governs the delivery of quality care and services at the service. The facility manager reports to the Board on clinical, leadership and governance matters. A review of the minutes for the Board meeting by the assessment team indicated that discussions included mandatory training, a new leadership coaching program, an appraisal of the clinical governance structure, outbreak management and continuous quality improvement plans.

The Assessment Team found the service did not meet Requirements (3)(c), (3)(d) and (3)(e). I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint under Requirement (3)(c) and (3)(e), and Compliant under Requirement (3)(d). I have provided reasons for these findings in the relevant requirements below.

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) 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 identified that the service was unable to demonstrate effective organisation wide governance systems relating to information management and regulatory compliance. Summarised relevant evidence included:

* Care planning documentation reviewed by the Assessment Team found an incident report had been created for a named consumer that had experienced significant weight loss, however there was no follow up action taken to manage this issue.
* Management presented inaccurate information to the Assessment Team regarding the amount of consumers subject to restrictive practices and consumers that were transferred to hospital following a fall, within three months preceding the Site Audit.
* As an additional twenty consumers were identified to be subject to environmental, chemical or mechanical restraints, the appropriate consent authorisations were not in place and the service was not compliant with restrictive practice regulations.

The Approved Provider’s written response, received 3 May 2022, outlined the actions taken and prospective actions within their continuous improvement plan, these included:

* Ensuring clinical governance policies, procedures and frameworks are current.
* The continued tracking and trending data for continuous improvements.
* Ensuring staff are educated on high impact and high prevalence risks including restrictive practices.
* A review of restrictive practice documentation to monitor compliance.
* Implementing immediate actions to address the named consumer’s weight loss issues.
* The tracking of weight loss through various information systems.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the identified issues, at the time of the Site Audit, the service did not demonstrate effective organisation wide governance systems. I therefore find this requirement Non-compliant.

### Requirement 8(3)(d) 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 was unable to demonstrate the effective management of high impact or high prevalence risks associated with the care of consumers. Summarised relevant evidence included:

* As previously described under Requirement 3(3)(b), a named consumer had care planning documentation that outlined rapid weight loss over the recent months. Following the significant weight loss, an incident report was created and reported to management. However, there is no evidenced actions or strategies taken to manage or minimise further weight loss. In addition, the consumer’s dietary assessment was recently reviewed, but did not reference the weight loss.

The Approved Provider’s written response, received 3 May 2022, outlined the actions taken and prospective actions within their continuous improvement plan, these included:

* Ensuring clinical governance policies, procedures and frameworks are current.
* Ensuring staff are educated on high impact and high prevalence risks.
* The implementation of immediate actions for the named consumer, such as regular food and weight monitoring, referral to dietician and review by a doctor. In addition, a case conference with the consumer and their representative to discuss a review of their care plan is to occur.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the service demonstrated discrepancies with risk management practices in relation to one named consumer, as addressed under Requirement 3(3)(a), I find the evidence brought forward by the Assessment Team insufficient to demonstrate systemic deficits in the effectiveness of the service’s risk management systems and practices. Therefore, I find the service Compliant with this Requirement.

### 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 identified that the service was unable to demonstrate an effective clinical governance framework in relation to minimising the use of restraint. Summarised relevant evidence included:

* Staff were unable to demonstrate a common understanding of the different types of restrictive practices and what constitutes a restrictive practice.
* Twenty additional consumers were identified to be subject to environmental, chemical or mechanical restraints than initially disclosed by the service, the required BSPs were not in place to outline the known behaviours of concern, and the alternative strategies in place to manage those behaviours and minimise restraint usage, for these consumers.

The Assessment Team raised the above issues with management during the Site Audit, management acknowledged that not all consumers subject to restrictive practices have the appropriate documentation in place. Management further advised they would complete the restrictive practice authorisation assessments for all consumers subject to restrictive practices.

The Approved Provider’s written response, received 3 May 2022, outlined the actions taken and prospective actions within their continuous improvement plan, these included:

* Ensuring clinical governance policies, procedures and frameworks are current.
* The implementation of alternative strategies prior to the use of restrictive practices.
* Providing training and education to staff regarding restrictive practices.
* Monitoring workforce training programs to ensure staff are trained to deliver safe and appropriate care.
* A review of consumer care planning and service documentation to ensure accurate monitoring and compliance with restrictive practices.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the identified issues, at the time of the Site Audit, the service did not demonstrate an effective clinical framework for minimising the use of restraint. I therefore find this requirement Non-compliant.

# 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 3(3)(a) – The service ensures that each consumer gets safe and effective care that is best practice, is tailored to their needs, and optimises their health and well-being.
* Requirement 3(3)(b) – The service ensures the effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 5(3)(b) – The service ensures the service environment enables consumers to move freely, both indoors and outdoors.
* Requirement 8(3)(c) – The service ensures effective organisation wide governance systems regarding information management and regulatory compliance.
* Requirement 8(3)(e) – The service ensures the service’s clinical governance framework minimises the use of restraint.