Performance

Report

**1800 951 822**

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| Name of service: | J E Murray Home |
| Service address: | 16 Deerness Way ARMADALE WA 6112 |
| Commission ID: | 7062 |
| Approved provider: | Dale Cottages (Inc.) |
| Activity type: | Site Audit |
| Activity date: | 19 September 2022 to 21 September 2022 |
| Performance report date: | 16 November 2022 |

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

**This performance report**

This performance report for J E Murray Home (**the service**) has been prepared by J Renna, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the Assessment Team’s report received on 20 October 2022.

# Assessment summary

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

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

# Areas for improvement

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

**Standard 1 Requirement (3)(d)**

* Ensure consumers are supported to take risks and the consequences of these risks are discussed and agreed management strategies implemented in consultation with consumers and/or representatives.
* Ensure staff have the skills and knowledge to identify, assess, monitor, and review consumers who wish to take risks.
* Review processes, policies and procedures relating to supporting consumers to exercise choice and independence.

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

* Ensure staff have the skills and knowledge to initiate assessments and update care plans where changes to consumers’ health are identified or when incidents occur.
* Ensure consumer care plans are updated and in line with legislative requirements, and are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures, and guidelines in relation to assessment, care planning and review.

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

* Ensure staff have the skills and knowledge to:
* recognise chemical restraint and implement appropriate non-pharmacological behaviour management strategies prior to administering psychotropic medication;
* initiate assessments, develop appropriate management strategies and monitor effectiveness of strategies relating to weight loss, wounds, pain and fluid restriction.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks.

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

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

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

* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers.
* Review the organisation’s clinical governance framework in relation to minimising the use of restraint.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Assessment Team was not satisfied the service demonstrated each consumer is supported to take risks to enable them to live the best life they can, as risks associated with consumers’ choices were not consistently assessed and documented to guide staff practice. The Assessment Team provided the following evidence relevant to my finding in relation to Requirement (3)(d):

* A risk assessment had not been undertaken and mitigation strategies were not implemented for one consumer who leaves independently and uses mobility device. Additionally, the service did not provide evidence demonstrating risks and interventions associated with these activities had been discussed with the consumer or that informed consent had been obtained, in line with the service’s policy and procedure. The consumer is experiencing moderate cognitive decline and has been assessed to be at risk of falls.
* Strategies were not documented in relation to one consumer’s choice to maintain a diet that is not in line with a Speech pathologist’s recommendations. While an informed consent form had been completed and signed by the representative, there was no evidence demonstrating discussion of the risks and agreed strategies had occurred.
* One consumer who self-monitors their fluid restriction did not have a risk assessment to ensure they are supported in their choice, and strategies to minimise associated risks were not documented.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes information and evidence to refute the Assessment Team’s assertions, which includes, but is not limited to:

* Mobility device review undertaken during November 2021, indicating physical, sensory and cognitive function had been considered and ability to operate had been assessed, for the consumer who chooses to use the mobility device. The ‘file creation’ date indicates this document was created during October 2022, which was after the Site Audit, and the document does not have a system ‘date stamp’ to show when the document was created.
* Acknowledgement that strategies for the use of the mobility device and leaving independently should have been documented.
* Swallowing assessment undertaken by the Speech pathologist during August 2022, demonstrating no concerns in relation to the consumer who chooses to maintain a diet that is not in line with a Speech Pathologist’s recommendations. This document shows the Speech pathologist assessed the consumer in relation to consuming a soft diet and not the types of food posing risk to their safety.

The response also included evidence of actions taken and/or planned in response to deficiencies identified by the Assessment Team. These include, but are not limited to, reviewed the risk form, developed a risk register for named consumers and added consumer risk to the Clinical risk meeting agenda. I acknowledge actions taken by the provider to address identified issues.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate each consumer is supported to take risks to enable them to live the best life they can.

I have considered that while a risk assessment may have been undertaken for one consumer who uses a mobility device and leaves independently, strategies to manage any associated risk were not documented to guide staff in maintaining the consumer’s safety. Additionally, there was no evidence that risks associated with their choices had been discussed with, and were understood by, the consumer, in order to obtain informed consent, in line with the service’s processes.

In relation to the consumer who chooses to maintain a diet that is not in line with a Speech pathologist’s recommendations, I acknowledge that strategies were documented by the Speech pathologist in their swallowing assessment. However, these strategies were not documented in the consumer’s care plan to guide staff in supporting the consumer to maintain a diet of their choosing in a safe manner. I have also considered that there was no evidence demonstrating discussions of risk and mitigation strategies had occurred with the consumer or representative, in line with the service’s processes.

In relation to the service’s failure to manage risks associated with one consumer who self-monitors their fluid restriction, I find the evidence does not align with the intent of the Requirement in relation to enabling consumers to live the best life they can. I find the evidence is more aligned with Requirement (3)(b) in Standard 3 Personal care and clinical care.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

In relation to all other Requirements in this Standard, overall, sampled consumers considered they are treated with dignity and respect, can maintain their identity and live the life they choose.

Consumers and representatives said staff are kind, caring, respectful and supportive of consumers’ identity, culture and diversity. Staff were knowledgeable of consumers’ personal history, cultural background, preferences and things of importance to them.

Care planning documents included individualised information about each sampled consumer, including preferences for care and aspects of their lives which are important to maintain their identity, culture and diversity. Staff provided examples of how they ensure care and services are culturally safe.

Consumers are supported to exercise choice and independence in relation to when they are assisted with personal care, what they would like for meals, preferred activities, and are encouraged to maintain their independence and personal relationships. Staff described how they engage with consumers to facilitate choice and independence.

Information provided to consumers is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. Staff said consumers receive information through various channels, including newsletters, meetings, forums, emails and one-to-one discussions. Consumers considered the level of information sufficient to make appropriate choices about their care and service delivery.

Consumers confirmed their privacy is respected and provided examples, such as keeping their door shut on request and knocking before entering. The organisation has procedures and processes in place to ensure consumers’ privacy is respected and confidentiality of consumer information is maintained.

Based on this evidence, I find the service compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice.

# Standard 2

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

Findings

The Assessment Team was not satisfied the service demonstrated assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. Specifically, while the service has admission assessment and planning processes to identify risks associated with consumers’ health and well-being, interventions were not individualised and did not guide staff in the management of consumers’ risks. The Assessment Team provided the following evidence relevant to my finding for Requirement (3)(a):

* The service’s policy requires staff to initiate specific care plans for complex care needs, such as catheter care, oxygen therapy, diabetes, colostomy and ileostomy. Eleven of 12 care plans sampled did not have specific care plans with goals or interventions to direct the management of their care.
* Care plans sampled did not consistently include sufficient details of interventions to manage risk associated with consumers’ care. For example:
  + The daily care profiles for three consumers who were identified as having high risk of falls were inconsistent with information in their falls risk care plans and did not include goals and interventions. The service’s policy requires assessment results to be documented in consumers’ care plans, however, this did not consistently occur.
  + One consumer identified as having pain has documented goals to improve quality of life by focusing on pain prevention and function, however, no pain management strategies were documented.
  + One consumer’s care plan did not detail monitoring requirements in relation to the use of restraint. Additionally, the consumer’s care plan was not updated to include current interventions in relation to pressure injury management and fluid restriction.
* Information and evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care demonstrated deficits in Behaviour support plans for three sampled consumers who are subject to chemical restraint. The sampled Behaviour support plans did not include personalised non-pharmacological strategies for staff to trial prior to administering psychotropic medication. Staff were not familiar with the Behaviour support plans, where to locate them and did not demonstrate knowledge of personalised strategies for sampled consumers.

It was unclear whether the provider disagreed with the Assessment Team’s findings. The provider’s response includes evidence of the service’s diabetes protocol form which is completed by the General practitioner. The response states that this form is used, as current software does not enable the documentation of complex care needs.

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

I have considered that relevant risks to consumers’ safety, health and well-being were not included in planning their care. The service did not follow its own processes by initiating care plans for complex care needs and ensuring risk mitigation strategies are documented, to direct management of consumers’ care. As a result, I find the service did not take measures to ensure consumers get the best possible care and make sure their safety, health and well-being are not compromised.

I have also considered that Behaviour support plans for three consumers subject to chemical restraint did not include sufficient information to inform care delivery, in line with legislative requirements.

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

In relation to all other Requirements in this Standard, overall, sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services.

There are processes to ensure assessment and planning identifies consumers’ needs, goals and preferences. Advance care and end of life planning are completed on entry, as part of care evaluation processes and any other time as needed. Staff described the care they provide to consumers receiving palliative care and confirmed this care would be informed by clinical staff and the service’s electronic management system.

Care plans were reflective of the consumer and inclusive of those involved in the care of the consumer, including relevant health specialists. One representative confirmed their involvement in assessment and planning processes during admission and on an ongoing basis.

Outcomes of assessment and planning are communicated to consumers and representatives at case conferences and via written correspondence. Consumers and representatives said consumers’ care plans had been discussed with them and they are able to view the care plan at any time.

There are processes to ensure 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. Twelve-monthly care plan review processes are in place to ensure all aspects of consumers’ care are aligned to their changing needs and preferences. Three representatives said staff consult with them to discuss changes in their family member’s health or care needs.

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

# Standard 3

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

Findings

Requirement (3)(a)

In relation to Requirement (3)(a), the Assessment Team was satisfied the service demonstrated each consumer receives safe and effective care that is best practice, tailored to their needs and optimises their health and well-being. However, information and evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care indicates best practice and tailored care is not being provided to consumers subject to chemical restraint, in order to optimise their health and well-being. For example:

* Chemical restraint was not used minimally and as a last resort for three sampled consumers subject to chemical restraint.
* Non-pharmacological strategies were not consistently trialled and documented before using chemical restraint.
  + One consumer was administered psychotropic medication to manage changed behaviours on approximately 21 occasions between August and September 2022. Documentation showed between July to September 2022, non-pharmacological strategies were trialled on only three occasions prior to administering the medication. Of the three occasions where non-pharmacological strategies were trialled, all known documented strategies were not used, including those recommended by Dementia Support Australia.
* Staff were not aware of Behaviour support plans or sampled consumers’ personalised strategies to be trialled prior to administering chemical restraint.

The provider’s response in relation to the evidence under Requirement (3)(b) in Standard 3 Personal care and clinical care has been considered. It is unclear whether the provider disagreed with the evidence in the Assessment Team’s report. The provider’s response includes evidence to support one consumer was not subject to chemical restraint, however, this consumer is not one of the three sampled consumers by the Assessment Team and is therefore not relevant to my finding.

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

I have considered that three consumers did not receive best practice and tailored care, as chemical restraint was not used minimally and as a last resort, which has resulted in the service’s failure to optimise these consumers’ health and well-being. I have considered that non-pharmacological strategies were not consistently trialled prior to administering psychotropic medication and where they were, all documented strategies were not used.

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

Requirement (3)(b)

The Assessment Team was not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of consumers, specifically in relation to wounds, pain, fluid, weight, and restraint. The Assessment Team provided the following evidence relevant to my finding:

* Documentation showed two consumers’ pressure injuries were not attended to in line with their documented interventions. One consumer’s wound was attended to every three days, despite Residential care line recommending this occur daily. The other consumer’s wound had not been attended for an eight-day period, despite their care plan saying it was to be undertaken every four days. Wound measurement inconsistencies were noted for both consumers. Photographs for one of the two consumers indicate their wound has further deteriorated since identification.
* One consumer’s pain assessment identified they experience pain, however, there was no further information documented in relation to the location of pain, goals and interventions. While the Assessment Team interviewed the consumer, there was no evidence indicating they had been questioned about their pain.
* One consumer was observed holding their mouth intermittently on each day of the Site Audit. The consumer told the Assessment Team they had oral pain. Documentation showed the consumer had three teeth removed during August 2022 and the representative said the consumer was due to have further extractions due to decay. Following the extractions undertaken during August 2022, the consumer was reviewed by a General practitioner, who recommended paracetamol and pain relief gel for any further sign of oral pain, however, there was no evidence indicating these interventions had been used. There was no evidence indicating any pain charting occurred in the five weeks prior to the Site Audit. The representative said the consumer has not been eating or drinking much, which they believe is as a result of their oral pain.
* Directives for monitoring of weight and amount of fluid restrictions were not documented for one consumer who self-monitors their fluid restriction. The consumer was observed to be out of breath and said this is a usual occurrence. The consumer said they are on a 750ml restriction and record their fluid intake in a book. Entries for the day reviewed showed the consumer drank one and a half cups of coffee, one cup of chocolate milk and two and a half large cups of apple juice. A 400ml jug of water was observed in the consumer’s room. The consumer said they believe they stick to their limit and no one from the service reviews their entries in the logbook.
* The service did not investigate weight loss and gain for three sampled consumers. Documentation showed one consumer had a six-kilogram weight gain over a one-month period, one consumer lost 3.9 kilograms over an 11-day period and another consumer’s weight significantly fluctuated over an approximate two-and-a-half-month period, including a 4.5-kilogram weight gain followed by a 9.2-kilogram weight loss. Management said they have increased consultations from a Dietitian from quarterly to bi-weekly and acknowledged issues with staff correctly recording consumers’ weight.
* There was no evidence that consumers with diabetes had diabetic management plans to guide staff in understanding consumers’ care needs and providing care.
* For three sampled consumers who were subject to chemical restraint, Behaviour support plans did not include, staff were not aware of, and staff were not documenting the use of, personalised and non-pharmacological strategies to be trialled prior to administering psychotropic medication.

It was unclear whether the provider disagreed with the Assessment Team’s findings. The provider’s response includes evidence to support one consumer was not subject to chemical restraint. The consumer noted in the response is not one of the three sampled consumers by the Assessment Team and is therefore not relevant to my finding.

The response also included evidence of actions taken and/or planned in response to deficiencies identified by the Assessment Team. These include, but are not limited to, emailed reminders to relevant staff of wound care procedures, and reviewed wound care and weighing procedures. I acknowledge actions taken by the provider to address identified issues.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate high impact or high prevalence risks associated with the care of consumers were effectively managed.

I have considered that two consumers did not receive wound care in line with their documented interventions, which resulted in the further deterioration of one consumer’s wound. While inconsistencies in wound measurement does not directly relate to ineffective management of the wounds, I strongly encourage the provider to conduct a review of all active wounds to ensure they have been correctly measured and recorded, and provide staff education to prevent inconsistencies in future.

In relation to the consumer who did not have documented interventions relating to their pain, while evidence shows the service failed to follow their assessment and planning processes, I have considered there is no evidence indicating the consumer’s pain was unmanaged. I find this evidence is more aligned with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

In relation to the consumer who was experiencing oral pain, I have considered that despite the consumer being visibly in pain and verbalising they had pain, the service failed to identify the consumer was in pain and administer documented interventions to ensure the consumer was as comfortable as possible.

I have considered the service failed to manage risks associated with one consumer who self-manages their fluid restriction. I acknowledge the service has enabled the consumer to make choices about how their care is delivered, however, despite being visibly out of breath, which the consumer says is a regular occurrence, no strategies were implemented to ensure the consumer was supported to do so safely.

I have also considered that risks associated with three consumers’ weight loss and/or weight gain had not been investigated to understand why it had occurred and implement management strategies to minimise the risk of harm.

In relation to the service’s failure to implement diabetic management plans to guide staff in understanding consumers’ diabetic care needs, I have considered there is no evidence indicating adverse outcomes for consumers on ineffective diabetes management. I find this evidence is more aligned with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

In relation to the service’s failure to minimise the use of restraint through documenting and trialling non-pharmacological strategies prior to administration of psychotropic medication, there is no evidence indicating ineffective behaviour management. I find this evidence is more aligned with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, Requirement (3)(a) in Standard 3 Personal care and clinical care and Requirement (3)(e) in Standard 8 Organisational governance.

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

Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g)

Overall, sampled consumers consider they receive personal and clinical care that is safe and right for them.

There are processes in place to ensure needs, goals and preferences of consumers nearing the end of life are recognised and addressed, with their comfort maximised and dignity preserved. The service works closely with an external palliative care service to ensure each consumer gets care that is right for them, including in relation to pain, comfort and medication. One consumer and their representative were satisfied with the palliative care the consumer was receiving and said they are consulted when any changes occur.

Documentation and interviews with staff showed deterioration in consumers’ health, cognition or physical function is recognised and responded to in a timely manner, including initiating appropriate referrals, conducting assessments and implementing additional clinical care congruent to changed needs.

Information regarding consumers’ condition, needs and preferences is documented on a care plan and readily available to staff and others where responsibility for care is shared. Staff said they access up-to-date consumer information through care plans and at handover. Consumers and representatives considered consumers’ needs and preferences are effectively communicated between staff.

Care planning documents showed timely and appropriate referral to other services and organisations for additional review and treatment of consumers’ health care needs. Consumers and representatives said referrals to other providers of services are made in a timely manner.

There are processes in place to support the minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection, and practices to promote antibiotic prescribing and use to reduce the risk of increasing resistance to antibiotics. Staff demonstrated knowledge of antimicrobial stewardship principles and described strategies used to minimise the need for antibiotics, and all staff have had training on infection control. Spot checks are performed in relation to personal protective equipment (PPE) donning and doffing, and improvement has been implemented as a result of a recent infection prevention audit. Screening processes are in place for visitor and staff sign-in.

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

# Standard 4

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

Findings

Overall, sampled consumers considered the service supports them to do the things they want to do, and which are important for their health and well-being.

Care planning documentation included a lifestyle and spiritual care plan, which detailed the interests and preferences of consumers. Staff demonstrated knowledge and understanding of consumers’ identified goals for optimising their independence.

Services and supports are in place to promote each consumer’s emotional, spiritual and psychological well-being. Staff explained how they respond to consumers who need additional support and were knowledgeable about strategies to support sampled consumers’ emotional, spiritual and psychological well-being.

Consumers described how they are supported to participate in their community within and outside the organisation’s service environment, have social and personal relationships and do things of interest to them, including participating in lifestyle activities, attending a knitting group, listening to books on tape and socialising.

There are processes in place to ensure information about the consumer’s condition, needs and preferences are communicated within the organisation, and with others where responsibility for care is shared. Staff said they are kept up-to-date with consumers’ changing condition, needs and preferences through handover meetings and by accessing consumers’ care plans.

Care planning documentation showed appropriate referrals to individuals, organisations and providers of other care and services for the provision of supports for daily living. Staff said consumers have access to specialists, such as Physiotherapists, Occupational therapists, Psychologists, mental health professionals, Speech pathologists and Dietitians.

All consumers and representatives interviewed gave positive feedback about the food and stated they are of suitable quality and quantity. Consumers confirmed they have access to snacks outside of scheduled meal times. The service has a seasonal menu, which is prepared by an external catering organisation and has been developed in consultation with consumers and a Dietitian.

Equipment used to support daily living was observed to be safe, suitable, clean and well maintained. Consumers said they have access to the equipment they need to mobilise safely, and staff demonstrated an understanding of preventative and reactive maintenance processes to ensure equipment is clean and in good condition.

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

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Sampled consumers feel they belong and feel safe and comfortable in the service environment. Consumers reported the environment is clean and well maintained, and they are free to use all communal areas.

Staff demonstrated how they ensure the service environment is clean and safe, including the process for actioning and prioritising internal and external maintenance.

The environment was observed to be welcoming and well maintained. The environment consists of five different wings, including a secure area for consumers with wandering behaviours. Consumers were observed utilising the internal and outdoor communal areas. General use and personal equipment appeared clean and well maintained.

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

# Standard 6

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

Findings

Sampled consumers considered they are encouraged and supported to give feedback and make complaints, and appropriate action is taken to address feedback and complaints.

The service has multiple mechanisms in place for providing feedback and complaints, including feedback forms, verbally, and residents and relatives’ meetings. Consumers were able to describe how they are supported to provide feedback or make a complaint and staff demonstrated an understanding of the feedback and complaints process.

Most consumers and representatives interviewed were aware of advocacy and external complaints services. Information relating to internal and external complaints processes and advocacy services was observed in communal areas.

Processes are in place to ensure complaints are followed up and appropriate action is taken. Most consumers and representatives said management has acted promptly and transparently in response to feedback and complaints. Staff demonstrated an understanding of open disclosure and how it applies to complaints resolution processes, and provided examples of actions taken in response to complaints. When feedback or a complaint is received, it is acknowledged, an apology is offered where appropriate, and actions taken to rectify the issue are provided.

Feedback and complaints are recorded and analysed to implement improvements for any trends identified. Consumers, staff and management provided examples of how the quality of care and services has been improved as a result of feedback and complaints, including installation of a sensory garden, changes to the menu and trialling an extension to the breakfast period.

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

# Standard 7

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

Findings

The Assessment Team was not satisfied the service demonstrated its workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following evidence relevant to my finding for Requirement (3)(c):

* Staff have received training, and policies and procedures are in place to guide staff in relation to responding to abuse and neglect. However, two incidents of absconding were not reported as required by the Serious Incident Response Scheme (SIRS). In relation to one of the two incidents, management did not consider it to be reportable as the consumer had only been missing for 30 minutes. In relation to the other incident, an incident form was not completed in line with the organisation’s policy.
* Staff failed to include personalised strategies in consumers’ Behaviour support plans, in line with legislative requirements. Three staff were unaware that Behaviour support plans existed and that they should refer to these to support consumers’ behaviours.
* Staff did not document alternate strategies trialled before, side effects and effectiveness of chemical restraint.
* Staff did not document consumer weights correctly.
  + Information in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care shows the service was aware of the issue and at the time of the Site Audit, were in the process of looking at new weight scale as the current ones are difficult to use.

It was unclear whether the provider disagreed with the Assessment Team’s findings. The provider’s response includes evidence demonstrating a SIRS flowchart was in place, and copy of the Commission’s SIRS decision support tool to show one of the two incidents of absconding were not reportable.

The response also included evidence of actions taken and/or planned in response to deficiencies identified by the Assessment Team. These include, but are not limited to, toolbox session and information sheet created to guide staff in Behaviour support plans, and commenced review of Behaviour support plans and psychotropic medication use. I acknowledge actions taken by the provider to address identified issues.

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

I have considered staff have knowledge deficits regarding incident reporting and the SIRS. I acknowledge the provider’s evidence that one incident of absconding, as stated in the Assessment Team’s report, was not reportable under the SIRS. However, for the other incident, staff failed to report it under the SIRS and complete an incident form as required under the organisation’s policy. I have noted that the provider’s response only asserts that one of the two incidents were not reportable.

I have also considered that staff were not competent in understanding their legislative obligations in relation to chemical restraint, as some were unaware of Behaviour support plans and that they should refer to them to support consumers’ behaviours, and they did not document alternate strategies trialled before, side effects and effectiveness of chemical restraint.

In relation to staff not documenting consumer weights correctly, I have considered information and evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care which shows the issue was known and being addressed.

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

In relation to all other Requirements in this Standard, overall, sampled consumers considered they get quality care and services when they need them, from people who are knowledgeable, capable, and caring.

Processes are in place to ensure the number and mix of staffing enables the delivery and management of safe and quality care and services. Consumers and staff considered staffing numbers to be sufficient in meeting consumers’ needs. Staff were observed attending to consumers in a timely manner and did not appear to be rushing.

Consumers and representatives said staff are kind and caring, and treat consumers with respect. The organisation has a code of conduct agreement, policies and procedures to guide staff in providing person centred care in a respectful, kind and compassionate manner, which staff were observed to be following.

Staff attend regular professional development or training to improve their knowledge, so they can effectively perform their roles. Staff attendance at mandatory training is monitored and specialised training is provided when needed. The service identifies the need for additional training based on incidents, feedback, observation, audit results, performance appraisals, and changes to industry standards, regulation and legislation.

Performance management processes are conducted three-months after commencement and annually thereafter. The service provided evidence of disciplinary action taken when deficits in staff practice have been identified.

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

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The Assessment Team was not satisfied the service demonstrated:

* effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers; and
* an effective clinical governance framework in relation to minimising the use of restraint.

As a result, the Assessment Team recommended the service does not meet Requirements (3)(d) and (3)(e) in this Standard. The Assessment Team provided the following evidence relevant to my finding:

Requirement (3)(d)

* For three consumers who choose to undertake activities that involve an element of risk, the risk management system was not effective in identifying risk assessments had not been completed in accordance with the organisation’s policies and procedures.
* For two consumers who absconded, the risk management system was not effective in identifying risk assessment processes had not been conducted, including reporting under the SIRS and via the service’s incident management system. Of the two consumers who absconded, it was confirmed that one and alleged the other, exited through the same door in one area of the service. Despite the two absconding incidents, the service did not undertake a risk assessment to determine if it was safe to have the door unlocked. This door was observed to be unlocked throughout the duration of the Site Audit, and opens directly onto the car park with no perimeter gate.
* Management reported clinical risks, such as falls, pressure injuries and weight loss, are benchmarked against other services, documented on a clinical indicator report, and discussed at clinical governance meetings. However, these systems were not effective in managing clinical risks for six sampled consumers, in relation to management of wounds, pain, fluid, weight loss and chemical restraint.

The provider did not refute the Assessment Team’s findings. The provider’s response included evidence of actions taken and/or planned in response to deficiencies identified by the Assessment Team. These include, but are not limited to, review of forms relating to informed risk. I acknowledge actions taken by the provider to address identified issues.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate risk management systems and practices were effective in managing high impact or high prevalence risks associated with consumers.

I have considered that risk management systems and practices failed to identify risk assessments had not been completed for three consumers who undertake risky activities, that assessments were not undertaken to maintain a safe environment following two absconding incidents, and deficits in care delivery occurred for six sampled consumers.

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

Requirement (3)(e)

* Management reported the service’s electronic care system limits their capacity to generate accurate reports in relation to psychotropic medication use and, as a result, pharmacy reports are used, and each consumer’s individual care record is accessed each month to determine if legislative requirements for chemical restraint have been met.
* Of the 12 consumers identified by the service as being subject to chemical restraint, the service did not meet their regulatory obligations in relation to three consumers sampled. Documentation showed non-pharmacological strategies were not consistently trialled and documented prior to the use of chemical restraint, staff did not consistently document the side effects or effectiveness of the medication, and Behaviour support plans did not include personalised non-pharmacological strategies to guide staff in managing the consumer’s behaviour. Additionally, staff interviewed were unaware of Behaviour support plans, where they are located, and strategies trialled for sampled consumers prior to administration of chemical restraint.
* Clinical risk meetings for July and August 2022 did not show discussion of chemical restraint and how it can be minimised.

It was unclear whether the provider disagreed with the Assessment Team’s findings. The provider’s response includes evidence demonstrating a procedure was in place for the development of Behaviour support plans, however, Behaviour support plans for named consumers were not provided to demonstrate they were in place at the time of the Site Audit. The response also states the service is in final negotiations with another electronic care system provider to ensure future needs are met.

The response also included evidence of actions taken and/or planned in response to deficiencies identified by the Assessment Team. These include, but are not limited to, commenced review of all Behaviour support plans and staff education and development of an information sheet to guide staff practice. I acknowledge actions taken by the provider to address identified issues.

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

I have considered that the organisation’s clinical governance framework failed to identify the service was not meeting its regulatory obligations in relation to chemical restraint. I have considered that chemical restraint was not being used as a last resort, Behaviour support plans did not contain sufficient information to guide staff in the use of non-pharmacological strategies and the effectiveness and side effects of medication was not consistently documented. While I acknowledge the service’s systems have limited capacity and negotiations are being finalised with another provider to ensure future needs are met, the Assessment Team was able to use current systems and extract sufficient evidence to determine the service was not meeting their regulatory obligations. I recommend the service reconsider their current processes to ensure better oversight of chemical restraint in the interim.

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

Requirements (3)(a), (3)(b) and (3)(c)

Overall, consumers sampled considered the organisation is well run and they can partner in improving the delivery of care and services.

Consumers and representatives are encouraged to make contributions to the way that consumers’ care and services are delivered. Feedback from consumers and representatives is sought via surveys, feedback and complaints processes, resident meetings and care plan review processes.

The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery by overseeing clinical governance, client experience, budgets, mandatory training and feedback.

Interviews with consumers, representatives and staff, and documentation showed there are effective organisation wide governance systems in place to support information management, continuous improvement, workforce governance, financial governance and feedback and complaints.

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

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