Kadimah Nursing Home

Performance Report

6 Cedar Street
KILLARNEY QLD 4373
Phone number: 07 4664 1488

**Commission ID:** 5455

**Provider name:** Killarney Memorial Aged Care Ltd

**Site Audit date:** 19 July 2022 to 21 July 2022

**Date of Performance Report:** 23 August 2022

# Performance report prepared by

Jodie Earnshaw, 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) | 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) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 15 August 2022.
* other relevant information held by the Commission including internal referrals received.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Overall sampled consumers and representatives confirmed that consumers are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Consumers and representatives interviewed confirmed that consumers are encouraged to do things for themselves, supported to take risks and that staff know what is important to the consumers. Consumers described the way their social connections are supported both inside and outside the service. They said that the service protects the privacy and confidentiality of their information, and that they are satisfied that care and services are undertaken in a way that affords them dignity and respects their privacy.

Staff interviewed were aware of consumers’ preferences, culture, values and beliefs and were able to explain how those preferences influence how care is delivered, including support consumers to make choices which may involve risks. Staff were observed to interact with consumers respectfully and could identify consumers’ individual preferences and interests.

Care documentation includes consumer profiles and lifestyle planning, which reflect consumer cultural background, social information and preferences for activities. Access to electronic and hard copy documents are protected to preserve confidentiality of consumer information, consistent with policies and procedures.

The organisation’s policies and procedures outline what it means to treat consumers with respect and dignity which guide staff practice relating to consumer choice, decision-making and risk management.

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

Consumers and representatives considered consumers are partners in the ongoing assessment and planning of consumers care and services, including consideration of consumer’s wishes for care at end of life and how other providers of care are involved in the consumers’ care. Consumers and representatives are informed about the outcomes of assessment and care planning by staff at the service and with external health care providers.

Staff demonstrated an understanding of the service’s assessment and care planning processes, and the organisation had policies, procedures and guidelines in regard to assessment and planning to guide staff practice, including a suite of evidence-based assessment tools.

The service had an electronic care management system. Review of consumers care planning documentation identified assessment and planning included the consideration of risk and reflected the consumer’s current needs, goals and preferences, including advance care planning and consideration of individual consumers’ risks. Consumers’ care and services were reviewed for effectiveness, including when circumstances changed or when incidents occurred.

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-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Assessment Team recommended Requirements 3(3)(a) and 3(3)(b) were Not Met, as deficiencies were identified in the service’s provision of safe and effective care, specifically in relation to management and monitoring the use of restrictive practices and safety of medication management.

Consumers and representatives sampled expressed confidence that when the consumer needs end of life care, the service will support them to be as free as possible from pain and to have those important to them with them. Staff demonstrated a shared understanding of their roles and responsibilities in recognising and addressing consumers nearing the end of their life.

Clinical records sampled reflect referrals and recommendations from a range of health professionals including medical officers, and other health care practitioners.

Clinical staff described the process of advanced care planning and palliative care. Staff were familiar with managing pain, repositioning, skin care and massage. Clinical staff provided examples of change in the condition of sampled consumers, how it was recognised and responded to in a timely manner. Staff advised they received training on recognising and responding to signs of deterioration in consumers’ health. Staff described the ways in which information was shared amongst staff, which included the electronic care management system, communication book and handover meetings.

The service is supported with documented policies and procedures in relation to minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. Staff interviewed were able to describe how infection related risks are minimised. The organisation maintained assessment tools in monitoring and assessing pain in consumers. The organisation had a risk management policy and procedures in place which guided how risk was identified, managed and documented.

The service demonstrated it had policies and procedures in place to manage end-of-life preferences for consumers. These were designed to maximise comfort and preserve dignity for consumers during the end-of-life stage and the service had registered staff on site 24 hours per day to support this. The organisation provided clinical pathways to guide staff in identifying and responding to a change or deterioration in consumers’ conditions.

The organisation had policies and procedures in place which guided staff practices in clinical governance and restraint management. However, the Assessment Team found the service did not demonstrate effective management of high impact and high prevalence risks for consumers under restrictive practise.

The service did not consistently demonstrate that:

* each consumer gets safe and effective personal or clinical care that is best practice, tailored to their needs and optimises their health and well-being particularly in relation to:
* identification, management and monitoring the use of restrictive practices
* in relation to high impact and high prevalence risks, the service was unable to demonstrate effective management and monitoring in relation to weight loss, fluid restriction management and medication management.

The Quality Standard is assessed as Non-compliant as one 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 service was not able to demonstrate that consumers sampled were provided with safe and effective personal and clinical care that is tailored to consumer’s needs and optimises their health and well-being in accordance with the service’s policies and procedures. The service did not demonstrate a shared understanding of restrictive practices and was unable to provide current assessment or authorisations for all restrictive practices used at the service.

The assessment team identified:

* inadequate identification, monitoring and management of the use of restrictive practices
* ineffective management and monitoring in relation to weight loss, fluid restriction management and medication management.

The service has policies and procedures in place to support the delivery of care provided, including in relation to restrictive practices, pressure injury prevention and management, and a pain management policy that incorporates ongoing pain assessment to guide staff practice.

The service monitors monthly clinical indicators to analyse and respond to high impact and high prevalence risks and discusses clinical indicators at staff meetings to identify improvements in the delivery of consumer care. However, the service did not have a shared understanding of restrictive practices including the use of chemical, environmental or physical restraints and were unable to provide assessments or current restraint authorisation for all consumers who have restrictive practices in place. For example, the site audit report provided information that:

* the service advised they do not close the doors to the secure unit, with consumers able move throughout the service freely as the doors always remained opened. However, the Assessment Team observed on 3 occasions during the Site audit that the doors to this unit was closed impeding consumers freedom of movement and from exiting the unit.
* Review of restrictive practice authorisations for the 7 consumers that reside in the unit identified 2 consumers did not have a current assessment or environmental restraint authorisation in place, nor did they have access to an electronic access card. The service was not able to demonstrate that an access card had been offered to these consumers but committed to ensure these consumers and future consumers will have access to electronic access cards and staff will be educated regarding the doors remaining open.
* Care documentation identifies one named consumer as using a wheeled walker for mobility, however the care documentation instructs staff to place the bed in a ‘low-low’ position with a sensor mat beside the bed as part of the consumers falls management. Management advised the assessment team, that the bed in a low position minimises the risk of falling and had not considered this action as a restrictive practice, as such the service had not conducted a risk assessment, obtained informed consent or have a current restraint authorisation in place. The approved provider in its written response did not respond to this aspect of the named consumer’s care.
* The service provided documentation to the assessment team and identified 3 consumers who were considered by the service as being chemically restrained. However, the psychotropic monitoring tool identified 6 consumers were chemically restrained. For example:
* One named consumer is receiving an antidepressant without a diagnosis of depression, and management advised this medication is used to stop the consumer from masturbating in public areas of the service. The service had not conducted a risk assessment, nor had they sought informed consent or have a restrictive practice authorisation in place for this consumer.
* Another named consumer is administered an antipsychotic medication without an associated diagnosis for this medication and did not have a risk assessment, obtained informed consent or have a restrictive practice authorisation in place. The site audit report provided information that Management advised the assessment team this consumer was not considered chemically restrained and the medication was prescribed for behaviour modification.
* One named consumer is prescribed a Benzodiazepine without an associated diagnosis for this medication, and the service was unable to demonstrate that the service had undertaken a risk assessment or obtained informed consent or that the service has a restrictive practice authorisation in place.

The Assessment Team also identified 5 consumers who had not been assessed or reviewed for weight loss, I have considered this more broadly under Requirement 3(3)(b).

The approved provider in its written response acknowledged the deficiencies identified and provided information and supporting evidence of actions that have been taken or planned since the Site Audit.

In relation to restrictive practises:

* The approved provider advised that the doors to the secure unit have been addressed electronically to remain unlocked 24 hours per day, and that the door had been closed at the request of a consumer to reduce a cold breeze and was inadvertently locking when closed.
	+ The service provided documented evidence of one named consumer declining, on entry to the service, an access card.
	+ The service has updated admission documentation to prompt offering of electronic access cards to consumers and to review psychotropic medication prescribed to reflect necessary authorisations and consents at time of entry to the service.
	+ The service provided information and evidence that 2 named consumers did have appropriate diagnosis for the administered medications however advised that risk assessments have now been completed.
	+ The service provided information and evidence that one named consumer did have a protective assistance form in place at the time of the audit, however the service has since completed a risk assessment for this consumer.
	+ The service has conducted and planned ongoing education for staff in relation to restrictive practises.
	+ The service has updated monthly clinical meetings and processes for improved clinical governance and oversight, particularly in relation to monitoring and review of restrictive practises.
	+ An external consultant pharmacist, reporting to the approved provider executive leadership; has commenced quarterly consumer medication reviews and staff training with a focus on psychotropic mediation management and usage within the service.

In relation to weight management:

* The service provided a response regarding one named consumer and weight management under Requirement 3(3)(b), under which, I have considered this aspect of care provision and compliance.

In coming to my decision of Compliance in this Requirement, I have considered the information included in the Site Audit report alongside the Approved Provider’s response. I acknowledge the approved provider has implemented and planned further actions to address the deficiencies identified by the assessment team, however, these improvements will take time to be implemented and evaluated by the service. Therefore, it is my decision that this requirement is Non-compliant as the service did not consistently demonstrate that each consumer gets safe and effective personal or clinical care that is best practice, tailored to their needs and optimises their health and well-being.

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

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

The Site Audit report provided information that the service did not demonstrate effective processes to manage the high impact and high prevalence risk associated with the care of the consumers. The assessment team identified:

Whilst some sampled consumers, high prevalence and high impact risks are identified in care planning documentation and have effective strategies in place to reduce the risk of harm to the consumer; the service was not consistently or accurately assessing consumers’ high impact risks, including weight loss and medication management at the time of the Site Audit. For example:

* Review of care planning documentation identified one named consumer had received assessment by a Dietician following unintentional weight loss and strategies to minimise risk of weight loss are documented in the consumer care documentation; however, the Assessment Team identified 5 other consumers had not been assessed or reviewed for weight loss, for example:
* For one named consumer, documentation evidenced, between April 2022 and July 2022 the consumer had lost a total of 3.45kg, however the service has not conducted monthly weighing or a review to determine cause of weight loss.
* Another two named consumers care documentation evidences a dislike of offered supplements and weight loss of 9.75kg in the last 6 months, and 6.05 kg in 3 months. The second consumer was reviewed in July 2022 when the representative raised concerns and requested a review by a medical officer.
* A further named consumer had not been weighed since May 2022.
* The service was unable to provide an explanation of why staff had not followed the service’s policy and consumer care documentation directions.
* For another named consumer, care planning documentation identifies requiring daily weighing and a 1.5 litre fluid restriction due to a risk of fluid overload and Congestive Cardiac Failure. However, a review of documentation, found that the service is not consistently monitoring the consumers fluid input or conducting daily weights as directed. The site audit report also identified for this consumer:
* On 8 occasions in a 2 month period (June/July 2022), the service did not document any fluid intake,
* on 11 occasions in the same 2 month period, the consumer had consumed less that 700mls of fluid in a 24-hour period. Care documentation does not evidence that the service had conducted an assessment or reviewed the consumers fluid input.
* The consumer was subsequently diagnosed with a Urinary Tract infection during this period,
* On 15 occasions during this period, the service did not evidence daily weights occurring as directed. A review of consumer weight records available identified the consumer had lost a total of 4.85kg in the last month.

The Assessment Team identified one named consumer whom self-administers medication via aPercutaneous Endoscopic Gastrostomy, stores their medication on their side table which is not a secure location.

* Management advised that whilst there is potential risk to other consumers by the medication not being secured, that they are respecting the consumers choice to have the medication on their bed side table. The site audit report advises that the service updated the risk assessment to include the consumers choice to have the medication on the side table and not in a locked drawer.

The approved provider in its written response acknowledged the deficiencies identified and provided information and supporting evidence of actions that have been taken or planned since the Site Audit:

In relation to safety of medication management:

* The service provided information that a suitable, secure cabinet has been provided to support one named consumer safely access and store medications for self-administration. I am satisfied this has addressed the risk posed to other consumers.

In relation to weight management of consumers:

* The service provided information and evidence of updated consumer risk assessments, specifically in relation to fluid restriction and weight management.
* The service advised one named consumer has experienced improved skin integrity and a fluid weight loss of 7 kilograms. The representative has requested the fluid restriction be removed and the Medical Officer has been contacted to review the Consumer.

The approved provider’s response acknowledges gaps in documentation of weights and fluid monitoring records; and described improvements implemented at the service, including:

* The service identified gaps in documentation were occurring when agency staff were on shift, therefore the service has introduced a procedure for staff to support agency staff in documenting consumer information daily.
* Clinical monitoring, as prescribed by the medical officer, such as fluid restriction monitoring and weight has been included in the electronic care management system to alert when due and will continue to alert staff until actioned. Senior clinical staff will monitor any outstanding tasks on a daily basis.
* Staff duties list and procedures have been updated to include review of weights, food and fluid charting and will be monitored by Management. This information was communicated to staff and discussed in a staff meeting on 3 August 2022.
* The service has introduced a weekly weight and vital signs report, reviewed by senior clinical staff to ensure consumers are weighed and reviewed as directed.
* Internal audits, including weight management audits, and clinical incidents will be reviewed by clinical management and reported to the Organisations governance, quality and risk committee monthly.
* Allied Health referrals will alert in the electronic care management system for follow up and visits impacted by COVID 19 restrictions will be scheduled as a remotely, such as telehealth appointments.
* Monthly clinical meetings will discuss and review consumer complex care needs, quality indicators trending and unplanned weight loss.

### In coming to my decision of Compliance in this Requirement, I have considered the information included in the Site Audit report alongside the Approved Provider’s response. I acknowledge the approved provider’s commitment to continuous improvement and the improvements implemented to address the deficiencies identified by the assessment team; therefore, it is my decision that this requirement is 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 considered that consumers get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers and representatives interviewed said:

* consumers have choice regarding meals, activities and their preferences relating to personal hygiene and care provision.
* consumers are supported to attend outings with their families, friends, volunteers and support workers.
* there is sufficient activity and choice available at the service which allows consumers to engage in activities at a level they feel comfortable with.
* the service supports consumers to keep in touch with people who are important to them through visitors attending the service, consumers take social leave and connecting with loved ones via telephone or video calls.

Consumer care planning documentation demonstrated assessment processes capture who and what is important to individual consumers to promote their well-being and quality of life ,and included information and strategies to support the emotional, spiritual and psychological wellbeing of consumers and information about external services, individuals and community groups who support consumers to maintain their interests and participate in the community outside the service.

Staff interviewed were able to explain how they identify when a consumer is experiencing a low mood and when they need to either provide additional support to the consumer or escalate an emotional need or concern to registered staff. Staff explained how consumers participate in the community and how they keep in touch with the people important to them. Staff interviewed reported they have access to the equipment they need and can access it readily when they need it. The Assessment Team observed equipment used to provide and support lifestyle services to be safe, suitable, clean and well maintained.

Staff described how changes in consumers’ care and services needs or preferences are communicated through verbal and documented handover processes, review of care documentation and meetings.

The lifestyle team described how they work with external organisations or utilise volunteers to help supplement the lifestyle activities offered within the service. The service activity calendars are reviewed regularly, and activities are adapted or changed depending on consumer feedback and evaluation of attendance.

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-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

Consumers sampled considered they feel they belong in the service and feel safe and comfortable in the service environment. Consumers and representatives interviewed confirmed consumers feel safe and find the environment comfortable and welcoming.

Consumers/representatives interviewed confirmed that consumers feel at home, and their visitors feel welcome. Consumers and representatives interviewed confirmed the service is clean and well maintained.

Management advised consumers were encouraged to personalise their rooms, access outdoor courtyards and communal areas and signage was available to assist consumers to navigate throughout the service.

Maintenance requests were recorded in logbooks and actioned by the service’s maintenance staff promptly. Equipment, furniture and fittings were observed to be safe, clean, well-maintained and suitable for use during the site audit.

Feedback in relation to the service’s living environment was received from consumers and representatives through consumer surveys and verbal and documented feedback processes. The service’s preventative maintenance schedule reflected regular maintenance of the service environment and equipment had been completed.

Whilst the service environment was safe, clean and tidy the service did not demonstrate a service environment that enables consumers to move freely, both indoors and outdoors. Doors leading to and from the services secured areas were locked, preventing consumers to move freely outdoors in the secured areas.

However, the Assessment Team identified areas within the service that were not safe or permitted access for some consumers to freely move inside and outdoors.

* Doors to the secure unit were observed to be locked on several occasions preventing consumers’ free movement.
* The secure unit outdoor area/pathway was observed to have potential hazards.
* The service’s designated smoking area for consumers does not support consumers to smoke safely.
* Medication for a consumer who self-administers their medication was left unlocked and accessible for other consumers.

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.*

Whilst the service environment was secure, clean and tidy, the service did not demonstrate a service environment that enables consumers to move freely, both indoors and outdoors. As doors leading to and from the services secured but reported as open unit were locked, preventing consumers moving freely outdoors in the secured areas.

Staff said the doors leading from the memory support unit to other areas of the service were permanently unlocked, however the Assessment Team observed these doors to be locked on a number of occasions during the Audit. Staff advised consumers have access to a ‘swipe card’ to enable them to freely leave the unit, however the Assessment Team identified 2 consumers do not have access to an electronic access card.

* I note in the Approved Providers response, information stating the doors were closed at the request of a consumer to reduce a cold breeze and was inadvertently locking when closed. The approved provider advised that the doors to the secure unit have been addressed electronically to remain unlocked 24 hours per day, consumers will be offered electronic access cards as required and staff education and monitoring is now occurring to ensure these doors remain unlocked. I further, note the approved providers commitment to continuous improvement. I have considered this more broadly under Requirement 3(3)(a) and I am satisfied that the service has addressed the identified deficiency.

### At the time of the Site Audit, the service was unable to demonstrate the environment was safe for all consumers. For example:

### the service’s designated smoking environment is entered via the service’s driveway and due to the structure and location of the smoking area consumers are not able to be observed by staff from inside the service and consumers do not have access to staff in case of emergencies. The smoking area is not equipped with a call bell.

### I note in the Approved Providers response, acknowledging the due to the location of the smoking area that staff supervision is not possible from inside the facility. The response provided information on improvements made or planned in relation to consumer safety when smoking; specifically:

###  Improved fire safety devices, such as extinguisher, fire blanket and fire robe.

### Alternative options for a smoking area will be considered.

### Consumers who choose to smoke will be supervised until such alternate arrangements are in place.

### The outdoor walkway from the secure unit posed hazards as the gardens and grassed area fall away from the concrete path, resulting in an increased falls risk for consumers and others accessing this area.

* + I note in the Approved Providers response, information stating hazards have been removed or barricades installed, and planned improvements for the outdoor area include refurbishment scheduled between September and December 2022.

### A consumer who self-administers their medications did not have their medications secured in a locked drawer.

* I have considered this under Requirement 3(3)(b) and I am satisfied that the service has addressed the identified deficiency.

In coming to my decision of Compliance in this Requirement, I have considered the information included in the Site Audit report alongside the Approved Provider’s response. Whilst I acknowledge the actions taken by the service to address the deficiencies identified at the time of the Site Audit, the service did not adequately demonstrate consumers are safe, specifically when smoking, the service had not identified this risk independently and whilst working towards improved safety and compliance in this area; improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is 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

Overall sampled consumers and representatives consider they are encouraged and supported to give feedback and make complaints, and that appropriate action is generally taken by management following concerns raised.

Staff interviewed were aware of how to access interpreter and advocacy services and were able to describe how they support a consumer who raises a complaint or escalate the complaint to management. Management demonstrated an understanding of open disclosure and was able to give examples of how they work with the complainant to resolve the issues to the complainant’s satisfaction and changes that have been made at the service as a result of feedback received.

Feedback, complaints and suggestions from consumers and representatives are sought through written feedback forms, consumer meetings and informal ways including speak to staff or management. Information of access to external complaints options and/or advocacy services were observed to be available to consumers and representatives.

The service is guided by policies in relation to feedback and complaints management and open disclosure, which informs continuous improvement in care and service delivery.

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 said there were enough staff at the service to meet consumers’ individual needs and preferences. They reported staff were kind, caring and respectful of consumers’ culture and diversity. Consumers and representatives felt staff knew what they were doing and performed effectively in their roles to support consumers’ needs.

Most staff interviewed considered there were enough staff to provide care and services to meet the needs and preferences of consumers and they were allocated enough time to complete their assigned tasks.

Unplanned leave was generally replaced by staff from the service, and some shifts covered by agency staff.

Staff had a shared understanding in relation to what was important to consumers and how they could support consumers to live the best life they can.

Staff were able to describe the training, support, professional development and supervision they receive during orientation which included buddy shifts with experienced staff members; and on an ongoing basis. Staff confirmed they can raise requests for further training and education which is supported by management.

Staff performance was monitored through appraisal processes, incident analysis and staff, consumer and representative feedback. The service’s staff performance framework included annual performance appraisals and opportunities for professional development.

Call bell response times were monitored, with delays in response for assistance investigated by management and discussed with staff.

Position descriptions established the responsibilities, knowledge, skills and qualifications required for each role. Mandatory and role specific training was completed and monitored by the service.

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.*

### 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-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Assessment Team recommended requirements 8(3)(d) and 8(3)(e) were Not Met, identifying deficiencies in relation to managing high impact or high prevalence risks for consumers and the service has not established effective clinical oversight and monitoring mechanisms in place to identify and respond to deficiencies in clinical and personal care of consumers with high impact or high prevalence risks.

Sampled consumers and representatives advised they felt the service was well run, and they can partner in improving the delivery of care and services by attending consumer meetings, participating in consumer surveys and submitting feedback to management.

Staff described the ways in which consumers were involved in decision making, which included feedback forms, discussions with staff and consumer and representative meetings.

Staff advised feedback was used in continuous improvement processes via feedback and the analysis of clinical indicators. Staff advised they were able to access the information they needed to perform their roles. Staff were able describe policies regarding high risk and high prevalence risk and provided examples of their relevance to their work. Staff demonstrated an understanding of strategies they implemented for individual consumers for falls prevention, pressure injuries, and to manage pain effectively.

Staff demonstrated an understanding of dignity of risk and provided examples of how they safely supported consumers to take risks and what measures the service had in place to monitor those risks.

Management described how the governing body of the organisation is accountable for the delivery of safe and quality care and services and promotes a culture of safe, inclusive and quality care and services for consumers.

Management described various ways the Organisation involves consumers in the development, delivery and evaluation of care and services.

The organisational risk management and governance framework is supported by relevant policies and procedures. However, the service was unable to demonstrate effective organisation wide governance systems and risk management systems and practices in relation to clinical oversight and restrictive practises:

* The service did not adequately demonstrate that consumers sampled were provided with safe and effective personal and clinical care that is tailored to consumer’s needs and optimises their health and well-being in accordance with the service’s policies and procedures.
* The service has not established effective clinical oversight and monitoring mechanisms in place to identify and respond to deficiencies in clinical and personal care of consumers with high impact or high prevalence risks.
* The service did not adequately demonstrate management and monitoring of high impact and high prevalence risks in relation to minimising the use of restrictive practices. Staff and clinical management were unable to demonstrate a shared understanding of restrictive practices. Clinical audits have not adequately identified deficiencies in the service’s management and monitoring of restrictive practice.

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

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

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

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

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

The service was unable to demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks for consumers at the service. The service has not established effective clinical oversight and monitoring mechanisms in place to identify and respond to deficiencies in clinical and personal care of consumers with high impact or high prevalence risks. For example:

The site audit report identified deficiencies in the management of high impact and high prevalence risks specifically weight management, fluid restriction management and medication management for sampled consumers.

* The Site Audit report provided information which identified 5 sampled consumers had not been regularly weighed, assessed or reviewed for weight loss. Fluid input had not been monitored or assessed for one consumer identified as being subject to fluid restriction as directed in their care plan documentation.
* The Assessment Team identified instances where consumer medication had been left accessible to other consumers and not stored safely.

Management advised the Assessment Team, clinical staff conduct clinical audits following an annual audit schedule, however acknowledged the clinical audits have not identified deficiencies and the organisation has subsequently identified the need to improve clinical oversight and monitoring by engaging an independent clinical governance and quality consultant.

The approved provider in its written response acknowledged the deficiencies identified and provided information and supporting evidence of actions that have been taken or planned since the Site Audit including:

* Improved provision and monitoring of mandatory staff education including restrictive practices and open disclosure modules.
* Implementation of training for staff conducting internal audits
* Review and evaluation of audit results
* Implementation of an internal Governance, Quality and Risk Committee, meeting monthly
* Financial budget of 2023 includes funding of an external clinical review process
* Consideration of appointment of a Compliance partner who will report directly to the Board and CEO.

In coming to my decision of Compliance in this Requirement, I have considered the information included in the Site Audit report alongside the Approved Provider’s response. Whilst I acknowledge the actions taken by the service to address the deficiencies identified at the time of the Site Audit, the service did not adequately demonstrate effective governance systems were in place in relation to effective risk management systems and practices in relation to managing high impact or high prevalence risks for consumers at the service; and improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-compliant.

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

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

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

Whilst the organisation had a policy in relation to minimising the use of restrictive practices, the service was unable to demonstrate an effective clinical governance framework is implemented in relation to minimising the use of restrictive practices. Some staff were unable to demonstrate a shared understanding of restrictive practices, clinical audits have not been consistently undertaken and have not identified deficiencies in the service’s management and monitoring of restrictive practice.

Information brought forward by the Assessment Team and included in the approved provider’s response demonstrated that the service was not complying with the legislative requirement to trial alternative strategies prior to utilising restraint.

Although Registered staff confirmed they had received education on restrictive practices and were able to describe various types of restrictive practices, including the need to seek alternative interventions prior to using any form of restraint and implementing strategies outlined under the consumer’s behaviour management plans to manage challenging behaviours. The Assessment Team identified various deficiencies with regard to the management and implementation of restrictive practices at the service, such as:

* The service’s psychotropic monitoring tool demonstrated 6 consumers subject to chemical restraint who, on review of care documentation, did not consistently have risk assessments, authorisations or consent in place.
* Another consumer is subject to mechanical restraint in the form of a bed in a low low position however did not have a risk assessment, authorisation and consent in place.
* Review of mandatory training records identified staff have not all received education in restrictive practices.
* The service’s clinical audit schedule identifies the service conducts monthly audits on restrictive practices within the electronic care management system; however, the assessment Team were only provided the restrictive practice audit conducted 7 March 2022 which demonstrated the service did not identify deficiencies in restrictive practice authorisation and consent for and by consumers.

The site audit report brought forward information that Management advised the organisation has recognised the need to strengthen clinical oversight and monitoring, therefore are engaging an independent clinical governance and quality consultant responsible to report to the Board information such as clinical and incident data, trending and detailed outcomes of clinical audits.

The approved provider in its written response provided information and supporting evidence of actions that have been taken or planned since the Site Audit, as outlined under the response of other requirements; including:

* the secure unit access doors have been addressed electronically to remain unlocked 24 hours per day
* the service provided documented evidence of one named consumer declining, on entry to the service, an access card.
* the service has updated admission documentation to prompt offering of electronic access cards to consumers and to review psychotropic medication prescribed to reflect necessary authorisations and consents at time of entry to the service.
* The service has conducted and planned ongoing education for staff in relation to restrictive practises.
* The service has updated monthly clinical and governance meetings and processes for improved clinical governance and oversight, particularly in relation to monitoring and review of restrictive practises.
* An external consultant pharmacist, reporting to the approved provider executive leadership; has commenced quarterly consumer medication reviews and staff training with a focus on psychotropic mediation management and usage within the service.

In coming to my decision of Compliance in this Requirement, I have considered the information included in the Site Audit report alongside the Approved Provider’s response.

I acknowledge the approved provider has implemented and planned further actions to address the deficiencies identified by the assessment team, however, these improvements will take time to be implemented and evaluated by the service. Therefore, it is my decision that this requirement is Non-compliant as the service did not consistently demonstrate an effective clinical governance framework is implemented in relation to minimising the use of restrictive practices.

# 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 approved provider 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, particularly for those consumers with complex or specialised care needs.
* Requirement 5(3)(b) – The approved provider ensures that consumers are able to move freely outside the service environment to the secured courtyards and gardens.
* Requirement 8(3)(d) –The approved provider ensures that the service has an effective organisation wide governance system relating to the management of high impact and high prevalence risk.
* Requirement 8(3)(e) –The approved provider ensures that an effective clinical governance framework is implemented in relation to minimising the use of restrictive practices.

**Other relevant matters**

* The Approved Provider implements all planned actions to address identified deficiencies and establishes monitoring process to ensure ongoing compliance with the Aged Care Quality Standards.