Performance

Report

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| Name: | Laurieton Lakeside Aged Care Residence |
| Commission ID: | 2793 |
| Address: | 349 Ocean Drive, LAURIETON, New South Wales, 2443 |
| Activity type: | Site Audit |
| Activity date: | 4 June 2024 to 6 June 2024 |
| Performance report date: | 19 July 2024 |
| Service included in this assessment: | Provider: 1332 Halenvy Pty Limited  Service: 1148 Laurieton Lakeside Aged Care Residence |

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 Laurieton Lakeside Aged Care Residence (**the service**) has been prepared by Julia Durston, 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 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 assessment team’s report received 10 July 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not 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 | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

* Requirement 3(3)(a): The approved provider is to ensure restrictive practices are used as a last resort and diabetes management is attended as directed by the medical officer.
* Requirement 3(3)(e): The approved provider is to ensure - there is a system and process in place to communicate and record information about consumers’ condition, needs and preferences in timely manner and is accessible to staff and others responsible for their care and services.
* Requirement 7(3)(c): The approved provider is to ensure it has an education program in place, and an effective training completion tracking system, to ensure staff and management have the competence to effectively perform their roles in line with legal and regulatory requirements, and to deliver safe, effective and quality consumer care and support.
* Requirement 8(3)(d): The approved provider is to ensure timely review of incidents and identification of mitigation strategies to facilitate accurate reporting of incidents and risk to the governing body to inform strategic mitigation of high impact high prevalence risks.
* Requirement 8(3)(e): The approved provider is to ensure that it has systems and processes in place to effectively monitor chemical restraint including administration of PRN psychotropic medication in line with regulatory and legislative requirements for restrictive practices.

# 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. | 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

This Quality Standard has been assessed as compliant as six of six specific requirements are compliant for the service.

**Compliant Requirements**

Requirement 1(3)(a)

The Assessment Team found most sampled consumers and representatives said consumers are treated with dignity and respect with their identity, culture and diversity valued. Sampled care planning documentation contained respectful language in relation to consumers. Management and staff spoke about consumers respectfully and demonstrated an understanding of their life history, background and preferences, and staff were observed respectfully interacting with consumers throughout the assessment, such as greeting and acknowledging them in communal areas.

Requirement 1(3)(b)

The Assessment Team found sampled consumers and representatives said staff provided care consistent with their cultural and religious preferences. Care planning documentation reflected their expressed cultural needs. Management and staff described how consumers’ culture and religious beliefs are acknowledged and supported and this was confirmed by consumers. The organisation has a lifestyle, risk and choice policy that addresses consumers’ cultural and spiritual life.

Requirement 1(3)(c)

The Assessment Team found consumers are supported to exercise choice and independence. Sampled consumers and representatives confirmed the service supports them to maintain relationships of choice and to make choices about their care. One consumer described how the service supports their partner and themself to spend time with each other, including having meals together in their room. Consumers were observed engaging with other consumers in the dining and entertainment areas of the service. Sampled care planning documentation included consumers’ individual choices regarding how and when care is to be delivered, who is involved in their care, and how the service supports them in maintaining relationships that are important to them.

Requirement 1(3)(d)

The Assessment Team found the service supports each consumer to take risks to enable them to live their best life. Sampled consumers advised how the service supports them to take risks which was consistent with the service’s dignity of risk policy. One representative described how the service supported the consumer to eat a normal diet despite the dietician recommending a pureed diet to prevent the risk of choking. The dignity of risk form for the consumer was signed by the representative and care planning documentation showed the general practitioner had discussed the risks with them. The form outlined the risks such as choking and described the risk mitigation strategies. Care and hospitality staff demonstrated an understanding of the consumer’s choking risk and mitigation strategies. The service has a dignity of risk policy.

Requirement 1(3)(e)

The Assessment Team found the service demonstrated that consumers and their representatives are given information that is current, accurate, timely and easy to understand, enabling them to exercise choice. Sampled consumers and representatives said they are informed about the activities at the service through printed information and verbal reminders. and if they do not understand any information, staff explain it to them. Information about activities was posted on noticeboards in communal areas. One representative provided positive feedback on how staff communicate with the consumer with a hearing impairment by demonstrating patience, communicating in a loud and clear voice and encouraging the consumer to wear their hearing aids to assist conversation. Staff described how they provide information to consumers in a way that meets their needs and preferences. For consumers living with sensory and cognitive impairments they assist them to make choices by using visual aids, picture cards, allowing time to understand what has been said and providing concise responses.

Requirement 1(3)(f)

The Assessment Team found overall the service demonstrated consumers’ privacy is respected and their personal information is kept confidential. All sampled consumers and representatives confirmed they felt the service respects consumers’ privacy during personal care, they knock on doors and seek consent prior to entry. The service has consumer privacy protocols and policies in place and staff practices were observed to be aligned to those protocols. The Assessment Team observed all nurses stations were locked and computers and the electronic care management system is password protected.

However, the Assessment Team noted care planning documentation for consumers’ who experienced falls included photographs of them taken immediately post fall as part of the holistic clinical assessment and incident investigation and the service’s post fall protocol. Management said they were unsure if this was an ethical issue, but advised consumers and representatives provide general consent for the use of photography for the purpose of care. The Assessment Team observed that incident reports contained photographs of consumers in a distressed state after their fall. One representative said they were not aware staff took a photo of their consumer post fall but did not express dissatisfaction with the practice. They said they were happy with the service doing it as long as it helped the consumer, and a consumer who was photographed post fall confirmed it was fine if it was required for documentation.

In their response to the Assessment Team report the approved provider advised they have reviewed their post falls policy and ceased the practice of taking photographs of consumers after they have had a fall.

Having considered the information regarding photographs taken of consumers post falls, I am not convinced that this is aligned with preserving consumers’ dignity. I commend the provider for the action it has taken regarding this issue

Based on the information summarised above, I find the service compliant in Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d), 1(3)(e) and 1(3)(f).

# 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. | 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

This Quality Standard has been assessed as compliant as five of five specific requirements are compliant for the service

**Compliant Requirements**

Requirement 2(3)(a)

The Assessment Team found the service mostly demonstrated comprehensive assessment and care planning is carried out that includes consideration of risks to the consumer’s health and wellbeing and informs the delivery of safe and effective care and services. The service uses a detailed checklist to guide the care planning process. Consumers and representatives said consumers receive the care and services they need. Care planning documentation showed risks are included to guide care delivery. Staff were able to describe consumers’ care goals and preferences aligned to their care plans. The care plan of one consumer identified as at risk of pressure injuries included a current skin assessment, which noted mitigation strategies including repositioning, use of an air mattress and pressure relieving booties. Staff were able to describe the comprehensive care directives from the care plan to manage a suspected deep tissue injury on the consumer’s heal. The consumer’s representative advised they are satisfied with the care planning and assessment process at the service. The Assessment Team noted that the care plan for one consumer lacked individualised behaviour support strategies. However, I have considered this in Requirement 3(3)(a).

Requirement 2(3)(b)

The Assessment Team found assessment and planning identifies and addresses consumers’ current needs, goals and preferences, including advance care planning and end of life care if the consumer chooses. Sampled consumers and representatives said assessment and planning identifies and addresses the consumer’s current needs and end of life preferences. One representative advised they were involved in end-of-life care planning for their consumer and expressed overall satisfaction with the end-of-life planning process. Management and staff described how they approach conversations about end-of-life care planning at admission, 3 monthly care plan reviews and regular follow ups. The service has a palliative and end-of-life care procedure that provides staff guidance to identify and manage end-of-life care needs, goals and preferences.

Requirement 2(3)(c)

The Assessment Team found the service demonstrated assessment, planning and review is based on a partnership with the consumer and those they wish to be involved and includes other providers involved in their care. This was evidenced in care planning documentation. Sampled consumers and representatives identified who was involved in consumers’ care, such as internal and external healthcare providers. One consumer representative said they were satisfied with their ongoing involvement in the care planning process and confirmed the involvement of a dementia support service in the assessment of their consumer.

Requirement 2(3)(d)

The Assessment Team found the service demonstrated the outcomes of assessment and planning are effectively communicated to consumers and documented in a care and services plan that can be easily accessed by consumers and staff at the point of care and service provision. Sampled consumers and representatives advised they were satisfied with the service’s frequent and regular updates on care and services. They said staff provide simple explanations about consumers’ clinical care, and that they have access to a copy of their care plan. Progress notes showed staff update consumers and representatives on care outcomes through in-person meetings, telephone calls and emails.

Requirement 2(3)(e)

The Assessment Team found that overall, the service demonstrated there is regular review of care and services for effectiveness and when circumstances change or incidents impact consumers’ needs, goals or preferences. Consumers and representatives advised staff regularly discuss consumers’ care needs and changes requested are addressed. Sampled consumer care plans showed the service conducts three monthly care plan reviews or earlier if consumers’ health, preferences or circumstances change, and there are monthly consumer of the day reviews. Care planning documentation for one consumer who had displayed changed behaviours towards a staff member showed a case conference was held with the representative the following day and the behavioural interventions in their care plan were reviewed. The consumer’s representative advised they were satisfied overall with their involvement in the care planning process. However, the Assessment Team noted that one consumer’s mobility care plan was not effectively reviewed as per the service’s post falls protocol.

Based on the information summarised above, I find the service compliant in Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e).

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Not 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

This Quality Standard has been assessed as non-compliant as five of seven specific requirements are compliant for the service.

**Findings of non-compliance**

Requirement 3(3)(a)

This Requirement was found non-compliant following an Assessment Contact conducted from 14 November 2023 to 16 November 2023. The service did not demonstrate that pain management and behaviour support strategies were in line with best practice and optimising consumer health and wellbeing.

During the current site audit conducted from 4 June to 6 June 2024 the Assessment Team found the service has implemented some actions to address the identified non-compliance. In summary the service reviewed all consumers subject to mechanical and environmental restrictive practices and audited prescribed psychotropic medications for those assessed as a high falls risk to ensure better practice interventions are in place. Between March and April 2024 psychotropic medication reviews were conducted to identify and deprescribe those that were no longer required for consumers. Restrictive practice polices were reviewed and the Assessment Team noted they were aligned to industry standards. The service delivered staff education on supporting consumers with changed behaviours and on pain recognition and management.

The Assessment Team found that while the service was effectively managing pain, and skin integrity, chemical restrictive practices were not always used as a last resort and diabetes management was not attended as directed by the medical officer.

Pain management

Four sampled consumers and their representatives advised they were satisfied overall with their pain management. Their care documentation evidenced effective pain management and staff were able to describe the pain assessment and management process.

Skin integrity

During the Site Audit the service had 3 consumers with an active pressure injury. Documentation and observation showed that for one consumer with a deep tissue injury on their foot documentation interventions to minimise the pressure injury were in place, such as the use of an air mattress and waffle cushion and heel protector. The representative mostly expressed satisfaction with the management of the consumer’s care. Documentation showed the wound was healing and wound dressing was applied as directed. However, documentation with wound photographs taken between May and June 2024 did not include a ruler to support wound monitoring as per the organisation’s wound care policy. Review of the service policy did not indicate wound photographs are to be taken with a ruler or how often. Management advised they would add a reminder regarding ruler use in the communication sheet distributed to clinical staff. The evidence presented did not show a negative impact for the consumer.

Behaviour management and restrictive practices

Management confirmed twenty consumers were subject to chemical restrictive practice at the service. The Assessment Team found that overall, the service demonstrated assessments for those sampled consumers met legislative requirements for chemical restraint, such as having a tailored and documented behavioural support plan, documented informed consent from their representatives, and systems in place for regular review and monitoring from the medical officer and registered nurses with day-to-day knowledge of sampled consumers. However, documentation did not reflect that the provision of PRN psychotropic medication as a last resort was consistently documented and/or monitored by the service. Care documentation for some sampled consumers showed staff did not always apply person centred behaviour support strategies. Staff described generic strategies for behaviour support such as attending to unmet needs and redirecting consumers. Some staff interviewed were not aware of their responsibility to document non-pharmacological interventions trialled.

The Assessment Team found the behaviour support strategies in one consumer’s behaviour support plan (BSP) were generic. Their representative said the service was revising their BSP but noted staff would benefit from further training on behaviour management. Care staff interviewed about the consumer advised their behaviour escalation can be rapid. Care staff described generic rather than individualised behavioural support strategies for the consumer, such as ‘redirection’. Care planning documentation for another consumer showed prescribed PRN medication to manage their agitation was administered before person centred support strategies were used, despite the consumer’s care planning documentation containing a range of non-pharmacological support strategies. Their representative advised they were satisfied overall with how the service supports the consumer’s changed behaviours. The representative of another consumer expressed their overall satisfaction with the behaviour support provided to the consumer by the service, but expressed concerns that the consumer may become agitated and display exacerbated behaviours when they are not wearing their hearing aids.

Management confirmed to the Assessment Team that restrictive practices were the service’s biggest risk, noting there was a high number of consumers on psychotropic medications. Management provided evidence the service had started working with medical officers to de-prescribe psychotropic medications in March 2024, but noted the service did not have a regular medical officer and did not provide a target date for completion of the reviews. Management described how the service plans to reduce restrictive practices by ensuring assessment of consumers’ unmet needs occur and engaging consumers in diversional therapy programs.

Diabetes management

The Assessment Team found documentation and consumer feedback showed that at times the service was not following diabetes directives for some consumer’s in relation to the frequency of blood glucose level (BGL) monitoring. One consumer noted their concern that their BGLs were not taken for a month when they should be taken on the 19th day every month. The consumer advised they had experienced dizziness and staff had not attended them in a timely manner resulting in a fall. BGL charts showed the consumer’s levels were not being checked monthly, but there were no episodes of hyperglycaemia or hyperglycaemia. Documentation for a second consumer with a diabetes directive of twice daily BGLs showed multiple instances where this had not occurred. Management investigated and found the BGLs were not recorded on the electronic care management system or the medication management system. However, the consumer expressed overall satisfaction with their diabetes management

In their response to the Assessment Team report the approved advised all diabetes care plans have been reviewed and updated and medical officers have reviewed and updated directives. Weekly audits are being completed by the deputy director of nursing and assistant director of nursing to ensure directives are being followed by registered staff. The BGL process has been streamlined. Weekly BGLs are now taken every Sunday and monthly BGLs are taken on Resident of the Day. The approved provider also outlined several improvements it is making to the management, review and monitoring of PRN psychotropic medication administered to consumers subject to chemical restraint. However, I consider it will take time for these improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 3(3)(a) non-compliant.

Requirement 3(3)(e)

This Requirement was found non-compliant following an Assessment Contact conducted from 14 November 2023 to 16 November 2023. The service was unable to demonstrate effective communication of information regarding clinical directives, and effective communication regarding identification of consumer deterioration to the organisation.

During the current site audit conducted from 4 June to 6 June 2024 the Assessment Team found the service has implemented some actions to address the identified non-compliance. The service implemented daily safety huddles (meetings) to enable teams to identify safety concerns and proactively identify risks, share information on serious incidents and when consumers commenced a palliative care pathway. The service deployed additional leadership resources including the commencement of a new deputy director of nursing to improve clinical oversite and communication on clinical matters.

The Assessment Team found the service was mostly able to demonstrate that progress notes and care and services plans provide information to support effective and safe sharing of consumer’s information to support care. However, some consumers and representatives reported that information about the consumer’s condition and needs was not effectively communicated within the service, negatively impacting their care.

Staff interviewed were unable to describe the diabetes monitoring program in place for one consumer. There were gaps in in the consumer’s blood glucose monitoring chart and the readings were not found in the electronic care management system or medication management system as suggested by management. I have considered this deficit and management’s response to it in Requirement 3(3)(a). The majority of sampled consumers and representatives said they frequently have to repeat information about their needs and preferences, in areas such as dietary requirements. The Assessment team noted two instances where staff were unable to recall consumer dietary preferences. These consumers advised they had raised complaints in the past about receiving the wrong meals, but the practice was ongoing.

In their response to the Assessment Team report the approved provider acknowledged there is room for improvement in this finding. The PCI supplied by the provider contains an action for the hospitality team to review identification of dietary preferences. Other consumer needs and preferences are recorded in the service’s electronic care management system as daily planned care and the service is considering monitoring important resident aids (such as hearing aids) as part of their huddle and handover process.

I acknowledge the approved provider’s commitment to make improvements regarding effective communication of consumers’ care needs and preferences. However, I consider it will take time for these improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 3(3)(e) non-compliant.

**Compliant Requirements**

Requirement 3(3)(b)

This Requirement was found non-compliant following an Assessment Contact conducted from 14 November 2023 to 16 November 2023. The service was unable to demonstrate that high-impact high prevalence risks such as consumer behaviours, falls and clinical incidents had been effectively managed to minimise clinical risks.

During the current site audit conducted from 4 June to 6 June 2024 the Assessment Team found the service has implemented some actions to address the identified non-compliance. In summary the service delivered staff training on behaviour management, incident management, post falls review, and the leadership team enrolled in dementia leadership training. A comprehensive review of falls was conducted that concluded most falls occurred in the evening in consumers’ rooms. The results of the review were reported to the clinical governance committee and a high impact high prevalence risk meeting in March 2024. Documentation evidenced a significant reduction in falls between February and May 2024.

The Assessment Team found consumers and representatives interviewed expressed their satisfaction at how high impact high prevalence risks were managed by the service and mostly described how interventions that had been put in place for each consumer were effective. Consumer representatives provided positive feedback on the service’s management of consumers’ changed behaviours, falls management and management of choking risks. Staff interviewed described the strategies in place to manage changed behaviours and pressure injuries. Care planning documentation for one consumer with changed behaviours evidenced that a person-centred behaviour support plan (BSP) was in place and that staff were aware of the interventions in place. Management and clinical staff were able to explain how they managed the risks associated with changed behaviours and described the involvement of dementia support specialists and external health practitioners as required. One exception to effective risk management noted by the Assessment Team was the delay between the initial identification of the weight loss and the date in which dietitian referrals were issued by the service for five consumers following documented weight loss. However, I have considered this in Requirement 3(3)(f).

Requirement 3(3)(c)

The Assessment Team found the service demonstrated that consumers who are nearing end-of-life have their dignity preserved and care is provided in accordance with their needs and preferences. The representative of a consumer receiving palliative care at the time of the Site Audit expressed their overall satisfaction about the care provided to the consumer. Documentation showed that repositioning, oral and eye care were attended and the consumers’ end-of-life wishes were attended too. Care planning documentation included the needs, goals and preferences of consumers receiving end-of-life care. Staff were able to describe how they care for end-of-life consumers through pain relief, regular repositioning and supporting family visits.

Requirement 3(3)(d)

The Assessment Team found changes in consumers’ mental health, cognitive and physical function, capacity and condition is recognised and responded to in a timely manner. Most consumers and representatives said the service is responsive to consumer care needs and staff would inform them of any change to their health, and planned management strategies. Staff were able to describe how they identify deterioration or change in a consumer’s health, capacity, or condition, such as observing variation in a consumer’s normal eating habits, behavioural changes such as agitation, or if they lacked interest in doing things they otherwise enjoyed. Review of documentation showed the involvement of specialists, including speech pathologists following a consumer’s choking incident and the noted change in their swallowing capacity.

Requirement 3(3)(f)

The Assessment Team found the service demonstrated although referrals to other providers of care and services are timely and appropriate for most consumers, they are not timely for consumers identified with weight loss. Most consumers and representatives interviewed said timely and appropriate referrals occur and that consumers have access to relevant health supports. Staff were able to describe the process for referring consumers to health practitioners. For sampled consumers, care planning documentation showed input was sought from and referrals where made when needed to specialist dementia services, medical officers, speech pathologists and physiotherapists. The representative of one consumer advised they have regular discussions about the consumer’s clinical condition with the medical officer and other specialists as required, and they confirmed that referrals to the dementia specialist service and other external specialists were timely and appropriate.

The Assessment Team found referrals to the dietician for weight loss were not always made in a timely manner and sited 5 examples of consumers who were not reviewed by a dietician up to two months after weight loss was identified. Management advised that most consumers sampled in relation to weight loss were on a palliative trajectory. Food and fluid charting was consistently attended for the consumers. The Assessment Team found sampled representatives and the consumer they were able to interview expressed overall satisfaction with the service’s management of the consumers’ weight loss.

Care documentation showed one consumer’s weight fluctuated from November 2023 to May 2024. The consumer was reviewed by the dietician on 26 March and returned to close to their original weight (of 74.7 kg) by 4 May 2024 weighing in at 73.5 kg. The representative expressed overall satisfaction with the service’s management of the consumer’s weight loss. The Assessment Team noted that one consumer with weight loss was on a palliative care pathway and was receiving chemotherapy. The consumer expressed overall satisfaction with the management of their weight loss. Another consumer experienced significant weight loss following admission to hospital for an infection in February 2024. The consumer was on palliative care pathway and then placed on end-of-life care in April 2024.

In their response to the Assessment Team report the approved provider advised weights are now reviewed at the beginning of each month using the service’s quality audit tool. Consumers within the 2% weight loss category in one month and 3% in 5 months will be reviewed by the medical officer and referred to the dietician. A new dietician commenced at the service on 24 July 2024 and provides quarterly onsite services, remote reviews between visits and emergency referrals as needed. The approved provider stated the representative of the consumer whose weight fluctuated between March and May 2024 (noted above), advised nil concerns regarding the consumer’s weight loss. The approved provider stated this was recorded on the case conference notes which may not have been viewed by the Assessment Team.

I acknowledge there was some delay in referral to the dietician for the consumers reviewed by the Assessment Team. However, overall review of the information provided by management in the Assessment Team report, either did not demonstrate significant negative impact for the consumers and/or showed there were palliative treatment and end-of-life care circumstances that influenced the consumers’ weight loss. Further, as stated the consumer and representatives interviewed were satisfied with the care they received. I commend the new system the approved provider has implemented to monitor weight loss. Accordingly, I find Requirement 3(3)(f) is compliant.

Requirement 3(3)(g)

The Assessment Team found the service demonstrated effective standard and transmission-based infection prevention and control practices and antimicrobial stewardship practices. Consumers and representatives said they were satisfied with the service’s management of COVID-19 precautions and other infection control practices. The service has an IPC lead who has completed the IPC course. The Assessment Team observed staff following all infection control procedures and the service’s COVID-19 screening procedure was strictly adhered to. The service has a process for enabling consumers to access antiviral medications within 24 hours of diagnosis including consumer/representative consent requirements. Staff demonstrated their knowledge of key infection control practices such as hand hygiene, donning and doffing and the effective utilisation of PPE, and clinical staff said antibiotics are prescribed following confirmed pathology. The service has documented policies and procedures to support the minimisation of infection related risks, including having a current COVID-19 management plan with delegations that all sampled staff were able to describe.

Based on the information summarised above, I find the service compliant in Requirements 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(f) and 3(3)(g).

# 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

This Quality Standard has been assessed as compliant as seven of seven specific requirements are compliant for the service.

**Compliant Requirements**

Requirement 4(3)(a)

The Assessment Team found all sampled consumers and representative described how the service supports them to engage in activities that meet their needs, goals and preferences and maximises their quality of life. Staff interviewed could describe what is important to sampled consumers and what they enjoy doing consistent with information contained in their care planning documentation. One sampled consumer said they were happy with their level of involvement, and noted the staff also respect their choice not to engage in activities when they do not feel up to it.

Requirement 4(3)(b)

The Assessment Team found the service demonstrated there are services and supports available to support consumers’ emotional, psychological and spiritual wellbeing. Consumers said the service supports them when they are feeling low, provides them with emotional reassurance and spiritual services are regularly offered in the activities schedule. One consumer described how the service supports them in their Catholic faith, including visits from the local priest and attending religious services. The activities calendar included activities to directly support consumers emotional, spiritual and psychological wellbeing such as one-on-one counselling, music therapy and chaplain visits. Lifestyle and care staff were able to describe consumer faiths and individual supports which aligned with consumers’ care plans, and management confirmed external psychological services and mental health services can be used to support consumers when needed.

Requirement 4(3)(c)

The Assessment Team found all sampled consumers and representatives advised that consumers are supported to participate within and outside the service, keep in touch with people who are important to them and do things of interest to them. One consumer said they enjoy their independence, the leave the service independently on trips with family and friends and take walks down by the lake to be part of the community. All sampled consumers and representatives said they were satisfied with how the service supports consumers to stay in contact with family and friends.

Requirement 4(3)(d)

The Assessment Team found the service demonstrated information about consumers’ condition, needs and preferences is communicated within the organisation and with others who share responsibility for consumers’ care. Staff advised they communicate and document changes in the electronic care management system and through staff handover at the beginning and end of each shift and staff meetings. Sampled care planning documentation contained adequate information to support safe and effective services and supports for daily living. One consumer advised their preferences in relation to their diabetic diet are communicated well within the organisation. Hospitality staff were able to name and describe the likes, dislikes and dietary preferences of sampled consumers consistent with their care planning documentation.

Requirement 4(3)(e)

The Assessment Team found the service demonstrated consumers receive timely referrals to individuals, other organisations and providers of other care and services. Sampled consumers and representatives said they are supported by other services and referred to other organisations when needed. One consumer described how they are regularly visited by a volunteer and said they were happy with them. Care and lifestyle staff advised the referral to a volunteer was made to support the consumer’s mental health as they struggled to settle into the service. Care documentation showed consumers receive timely referrals to other service providers.

Requirement 4(3)(f)

The Assessment Team found most sampled consumers and representatives expressed overall satisfaction with the quality and quantity of food provided by the service. All sampled consumers with dietary needs said their needs were accommodated and all staff demonstrated their knowledge of consumers’ dietary needs. The Assessment Team observed consumers were able to request alternatives such as salads and sandwiches.

However, some sampled consumers and/or their representatives provided negative feedback regarding the meal service including lack of food variety and meals that did not meet consumers’ dietary preferences. Hospitality staff said that consumers can request anything, and they will do their best to cater for it. Consumers are given a choice of two main meal options and inform the staff of their preferred meal and the service has two seasonal rotational menus. Hospitality staff acknowledged that consumers were still receiving the wrong meal on occasion and acknowledged there were deficits in communication regarding consumers’ food likes and dislikes and dietary needs. Hospitality staff said they have implemented new systems to resolve the issue, including a tag system that illustrates dietary preferences accompanied by a picture of the consumer on each consumer’s plate prior to being served. However, I have considered this in Requirement 3(3)(e).

Requirement 4(3)(g)

The Assessment Team found the service demonstrated that where equipment is provided to consumers it is safe, suitable, clean and well maintained. Consumers confirmed this in relation to equipment such as mobility aids, with one consumer advising staff wipe down their 4-wheel walker regularly. The Assessment Team observed a range of equipment, such as 4-wheeled walkers, wheelchairs, medication trolleys and leisure and lifestyle equipment that was suitable, clean and in good condition.

Based on the information summarised above, I find the service compliant in Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g).

# 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

This Quality Standard has been assessed as compliant as three of three specific requirements are compliant for the service.

**Compliant Requirements**

Requirement 5(3)(a)

The Assessment Team found consumers and representatives said the service environment is welcoming, easy to understand and makes them feel at home. They said they have a say in the design of the service environment and this creates a sense of belonging, independence and function. The Assessment Team observed the service has courtyards, dining, lounges and activities areas that facilitate free movement for consumers and promote belonging and interaction. The Assessment Team observed the service environment to be welcoming, with sufficient lighting, handrails for consumers to move around, and clear signage throughout the service for room numbers and personalised photos if requested by consumers.

Requirement 5(3)(b)

The Assessment Team found sampled consumers and representatives said the service environment is safe, clean, and well-maintained and allows them to move around freely both indoors and outdoors. Maintenance staff advised they use a combination of manual and online systems to monitor reactive and preventive maintenance jobs. One consumer gave feedback that they were happy with the maintenance team’s response time and actions taken to address the faulty mechanism to raise their bed. The Assessment Team observed environmental services staff cleaning communal spaces and consumer rooms on each day of the Site Audit.

Requirement 5(3)(c)

The Assessment Team observed, and all sampled consumers confirmed, that equipment, furniture, fittings and mobility aids are cleaned and maintained regularly. Care staff said they are responsible for cleaning personal mobility devices such as wheelchairs and hoists after each use and periodically throughout the shift. The previous fortnightly maintenance schedule showed equipment at the service was maintained and serviced on a regular basis.

Based on the information summarised above, I find the service compliant in Requirements 5(3)(a), 5(3)(b) and 5(3)(c).

# 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

This Quality Standard has been assessed as compliant as four of four specific requirements are compliant for the service.

**Compliant Requirements**

Requirement 6(3)(a)

The Assessment Team found all sampled consumers and representatives advised they can provide feedback and make complaints via feedback forms, consumer meetings, or directly to staff, and they all said they would feel safe to do so. Consumers and representatives reported that they feel comfortable and empowered to provide feedback to the service. The Assessment Team observed information displayed throughout the service that supports and encourages consumers and representatives to provide feedback and complaints. The service’s feedback forms are located at the entrance and in each nurses stations next to a locked letter box for the forms to be submitted anonymously. Staff were able to describe the feedback and complaints mechanisms available to consumers.

Requirement 6(3)(b)

The Assessment Team found consumers and representatives were able to describe external complaints and advocacy services and interpreter services they can access. Information on how to make complaints and advocacy services was displayed and observed to be readily available to consumers and representatives throughout the service. A consumer noted the session with an external advocacy organisation during the March 2024 consumer meeting which was documented in the meeting minutes. Management and staff described advocacy services available to consumers.

Requirement 6(3)(c)

The Assessment Team found most sampled consumers and representatives said the service responds to and resolves their complaints and concerns when they raise them or when an incident has occurred. Management and most staff demonstrated an understanding of open disclosure when things go wrong. Sampled complaints showed the service takes appropriate action in response, practices open disclosure, resolves the issue and mostly keeps the consumer informed throughout the complaints process. The service’s feedback and complaints register showed complaints are documented and appropriate action is taken in a timely manner. Two of seven sampled consumers and representative said that while management did respond to their complaints, they were not satisfied with the resolution and encountered the same issue repeatedly. When this was raised with management, they described multiple strategies they had tried in consultation with the consumers to resolve their complaints, and committed to trialling further strategies.

Requirement 6(3)(d)

The Assessment Team found feedback and complaints are reviewed and used to improve the quality of care and services. One consumer noted their satisfaction with the response to their feedback regarding the need for a fridge in the common kitchenette to provide consumers access to drinks and snacks outside mealtimes. Management said this prompted them to implement the ’24-hour dining and access to fluids’ project. The project was outlined in the service’s plan for continuous improvement and completed in May 2024. The service plan for continuous improvement contained several actions referencing consumer feedback and complaints

Based on the information summarised above, I find the service compliant in Requirements 6(3)(a), 6(3)(b), 6(3)(c) and 6(3)(d).

# 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. | Not 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

This Quality Standard has been assessed as non-compliant as four of five specific requirements are compliant for the service.

**Findings of non-compliance**

Requirement 7(3)(c)

This Requirement was found non-compliant following an Assessment Contact conducted from 14 November 2023 to 16 November 2023. The service was unable to demonstrate the workforce had the knowledge and skills required in relation to navigating the electronic care management system, incident management, behaviour support and restrictive practices.

During the current site audit conducted from 4 June to 6 June 2024 the Assessment Team found the service had implemented actions to address the identified areas of non-compliance. Care and clinical staff and management received training on restrictive practices, skin integrity, behaviour management, complex care, incident management and antimicrobial stewardship from October 2023 to March 2024. A dedicated RN was allocated to train staff to navigate the electronic care management system and staff confirmed they were confident in navigating the system. The service developed a flow chart to guide staff on incident management process and the Serious Incident Response Scheme (SIRS). Documentation showed management completed SIRS refresher training in January 2024.

Overall, the Assessment Team found actions taken in response to the non-compliance have not been effective. Documentation showed staff, such as registered nurses and care staff, have appropriate qualifications for their roles. However, the Assessment Team found there were deficiencies in staff knowledge and skills in relation to areas of incident management, restrictive practices and falls management.

Half the staff interviewed were able to describe their understanding of key topics related to their mandatory training such as open disclosure, restrictive practices and SIRS management. Clinical staff were unable to explain restrictive practices and how they should be used as a last resort. I have considered this in Requirement 8(3)(e). Two out of 3 sampled care staff were unable to describe the post-falls process in accordance with management expectations.

In their response to the Assessment Team report the approved provider advised they have decided to change to a new online learning platform to provide more engaging and interactive learning to assist staff with learning retention. The service has expedited restrictive practice mandatory training and staff must complete the training by mid-August 2024. Onsite training will be provided to registered and enrolled nurses and the management team at the end of July 2024 and mandatory online training on behaviour management, using the new platform, will be brought forward to August and September 2024. The approved provider acknowledged there is need for ongoing behaviour management and dementia support training program required to support residents.

I commend the approved provider’s acknowledgement and commitment to improve the quality of staff learning and retention through the implementation of a new, more interactive and engaging online learning platform, toolbox talks and other training programs it has brought forward in key areas such as behaviour support, dementia care and restrictive practices. However, I consider it will take time for these improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 7(3)(c) non-compliant.

**Compliant Requirements**

Requirement 7(3)(a)

The Assessment Team found the service did not demonstrate the workforce is planned and the number and mix of staff deployed enables the delivery and management of safe, effective, quality services. One out of 10 consumers and representatives interviewed expressed overall satisfaction with the number of staff and the speed at which care needs are responded too. All sampled staff said there are note enough staff and they are unable to complete their tasks to provide the required quality of care and services. Documentation mostly evidenced adequate staffing and that staff allocation is monitored by management. Management described how unplanned absences were filled by extending the shift times for staff rostered, offering permanent staff additional shifts, by using their casual staff pool or by using agency staff as a last resort. The Assessment Team did not observe staff to be rushed while they provided care to consumers during the Site Audit.

The Assessment Team reviewed unfilled shifts for the month of May 2024 which recorded that 17% of care staff shifts were unfilled and there were no unfilled shifts for clinical staff. Management added that they are meeting their care minutes requirement and have RN services 24 hours a day, 7 days a week as evidenced by their roster. Staff allocation sheets from the week preceding the Site Audit showed that seven care staff shifts were unfilled and there were no unfilled clinical staff shifts, demonstrating that there is an RN onsite 24 hours per day 7 days a week.

One consumer said they require two staff to assist them with going to the toilet. However, they said they have to wait more than 10 minutes for staff to attend to them because staff struggle to find an additional team member to assist. Another consumer said the shortage of staff has resulted in delayed meal service such as breakfast resulting in them receiving cold toast. The consumer said management had advised the consumer to seek assistance from staff to make more toast for them but was unable to find available staff. Management said they would follow this up with staff.

Care and clinical staff members said there are not enough staff in the service and this results in them rushing when delivering consumer care, delays in responding to consumer call bells, meals being served late, some consumers spending more time in bed than others and some consumers not getting showered as often as they like.

Management advised in response to the Assessment Team feedback that they are meeting and exceeding their care minute requirements and that staff may not be aware of the funding model and that they will include this as an agenda item for upcoming care staff and clinical staff meetings in June 2024.

In their response to the Assessment Team report the approved provider disputed that the service does not have a sufficient mix of workforce to deliver and manage safe, quality care and services. The approved provider supplied the total paid staff levels from the Quarterly Financial Report and advised the service rosters 220 minutes of AIN/RN time to meet the mandated care minute requirements. The approved provider stated the service rosters well above their mandated care minutes to ensure coverage due to ongoing issues of workforce availability such as staff illness/symptoms. In the quarter ending 31 March 2024 the service exceeded the required direct care staff minutes per resident per day by 12 minutes. It had a 5.57-minute deficit in registered nurse minutes per resident per day but supplemented this with 12 minutes extra direct care staff minutes. The approved provider noted difficulties faced by regional areas such as Laurieton with registered nurse availability. Further the approved provider noted that the number of call bell response times over 10 minutes compared to those within the 10-minute response time was 1.8% which they attributed to emergency situations an unexpected care events with other residents.

The approved provider also noted they have stabilised their care management capability as the service now has a director of nursing, assistant director of nursing and a newly appointed deputy director of nursing.

I acknowledge the consumer feedback provided in the Assessment Team report regarding consumer waiting times for personal care assistance and meals due to insufficient staff. However, I place weight on call data that showed 1.8% of call bell wait times from May 2024 and April 2024 exceeded the service’s standard od 10 minutes. I am satisfied the approved provider’s statement that these delays could be caused by emergency situations and unexpected care events for consumers is realistic. I also consider that the approved provider’s reporting on mandatory direct care and registered nurse minutes per consumer per day shows a commitment to meeting legislated requirements. I note that the service is temporarily supplementing the deficit in registered nurse minutes per consumer per day but is meeting its 24/7 registered nurse coverage requirement. Accordingly, I find the service compliant in this requirement.

Requirement 7(3)(b)

The Assessment Team found most consumers and representatives interviewed said that staff are kind, caring, respectful and gentle. Staff were observed to greet consumers by their preferred name, interacted with them in a positive and caring manner and demonstrated they were familiar with each consumer’s individual needs and identity.

Requirement 7(3)(d)

The Assessment Team found sampled consumers and representatives said staff performed their roles effectively, and they were confident in staff skills to meet their care needs. Staff said they complete mandatory training and competencies as part of their orientation process and then annually. The mandatory training schedule includes topics such as manual handling, incident reporting, the Quality Standards, fire safety, infection control and elder abuse. Training records showed training completion rates for mandatory training, including code of conduct, open disclosure and Serious Incident Response Scheme (SIRS) were 74.19%, 73.54% and 75.48% respectively. One representative said staff would benefit from more training on behaviour management. This was also noted by an allied health provider interviewed by the Assessment Team, in relation to consumers living with dementia. The Assessment Team found the service has training scheduled on behaviour management and restrictive practices for October 2024. The service was unable to provide training completion rates for staff who had participated in restrictive practice training.

In considering this requirement I have also considered the approved provider’s response to Requirement 7(3)(c) that outlined the actions the organisation is taking to improve, increase and bring forward learning activities for staff in areas such as behaviour and dementia support and SIRS, to remove current gaps in staff knowledge. During the Site Audit the organisation showed its commitment to staff training and development to equip staff to deliver the outcomes required by the quality standards and track staff training completions. Having since reviewed its current learning system and resources it has chosen to move to a more engaging and interactive online learning platform and to bring forward its training schedule in key areas of care and service delivery, regulatory and legislative requirements.

Requirement 7(3)(e)

The Assessment Team found the service undertakes regular assessment, monitoring and review of staff performance, goals are set by staff, and action is taken in response to staff performance. Management described how the performance of staff is monitored through formal performance appraisals and informal monitoring and discussions. Records showed staff performance appraisals had a 98.75% completion rate in May 2024. Review of a completed annual performance appraisal for a care staff member, outlined key areas of responsibilities, achievements and required improvements.

Based on the information summarised above, I find the service compliant in Requirements 7(3)(a), 7(3)(b), 7(3)(d) and 7(3)(e).

# 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. | Not 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. | Not Compliant |

Findings

This Quality Standard has been assessed as non-compliant as three of five specific requirements are compliant for the service.

**Findings of non-compliance**

Requirement 8(3)(d)

This Requirement was found non-compliant following an Assessment Contact from 14 November 2023 to 16 November 2023. The service was unable to demonstrate that the contributing factors associated with an incident were identified and that consumers were engaged in the evaluation of incidents.

During the current site audit conducted from 4 June to 6 June 2024 the Assessment Team found the service has implemented actions to address the identified areas of non-compliance and noted they were somewhat effective. The service commenced and is currently investigating and closing off outstanding incidents from January 2024 to May 2024, and the service updated its incident management policy.

The Assessment Team found the service’s risk governance systems and processes were still not effective in areas such as chemical restrictive practices, incident reporting and SIRS reporting.

The Assessment Team requested clinical indicators pertaining to behavioural incidents, which was noted as one of the service’s high impact high prevalence risks. However, management advised that at the time of the Site Audit, the service did not run reports on behavioural events. Management said that the service requires a ‘better system in place’ and acknowledged that the service was working towards ensuring behavioural related incidents are recorded in the clinical indicators. The Assessment Team further found the service was not meeting legislative requirements for the management of chemical restrictive practices, noting that PRN psychotropic medications were not always administered as a last resort, after appropriate use of behavioural support strategies aligned to consumers’ care plans.

Management advised that incidents are reviewed promptly and in a timely manner to mitigate risk and that the deputy director of nursing completes post-incident reviews 24 to 48 hours following incidents. The deputy director of nursing said incident reporting should be done on a daily basis, but they acknowledged there has been a backlog of incidents that require review. The Assessment Team reviewed care planning documentation for one consumer who experienced 2 choking episodes, and noted the incidents were reviewed one week following the initial incident and 10 days following the second. Management also said clinical management review the incident register weekly to provide oversight in case of missed reporting. However, as the reviews are running behind, I am not satisfied the weekly incident review would be based on accurate information, nor would organisational incident reports going to the board necessarily reflect the true profile of high impact high prevalent risks at the service.

The Assessment Team found the service is not meeting its legislative reporting obligations in relation to SIRS reports. Documentation showed that some Priority 1 and Priority 2 SIRS incidents were not reported within required legislative timeframes, including 2 Priority 1 incidents not reported within the required 24-hour timeframe with one taking 3 weeks to be reported. Some Priority 2 incidents were not report for approximately 2 months, when the required timeframe is within 30 days.

Management advised they identify high impact high prevalence risks through clinical indicators, internal audits, and regular reporting, and manage these risks in line with the service’s policies and procedures. The agenda for the high impact high prevalence risk meeting dated 5 March 2024 showed it was attended by management and risk mitigation strategies were discussed. Half of staff sampled were able to explain how they would escalate incidents of abuse and neglect as part of the incident management system.

In their response to the Assessment Team report the approved provider supplied a copy of their plan for continuous improvement, which shows several actions the provider is taking to improve the management of restrictive practices including the auditing of PRN psychotropic medication usage, behaviour management incidents, review of behaviour support plans containing generic behaviour support strategies, regular review of the psychotropic register with additional input from the new onsite pharmacist position. The approved provider also noted they are working with their electronic care management system provider to generate behavioural incident reports. The approved provider advised that timely reporting of SIRS incidents is an ongoing PCI activity, and the SIRS and incident management policy has been updated. Further, the provider advised toolbox talks, spot audits and face-to-face revision in huddles will be conducted to reinforce and fill staff knowledge gaps in relation to SIRS principles and open disclosure.

I acknowledge the improvements the provider has commenced and committed to in its PCI to return to compliance in this requirement. However, I consider it will take time for these improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 8(3)(d) non-compliant.

Requirement 8(3)(e)

The Assessment Team found the service has frameworks, policies and guidelines to minimise the use of restraint, antimicrobial stewardship, and open disclosure. Management and sampled staff were able to describe how these policies and procedures were applied in the delivery of care and services. However, the service did not demonstrate an effective clinical governance framework in the identification, monitoring and minimisation of restrictive practice. In particular PRN use of psychotropic medications for consumers subject to chemical restraint.

In relation to antimicrobial stewardship, clinical staff advised that antibiotics are commenced following a confirmed pathology result. Management said benchmarking of infections and use of antimicrobial medication are conducted and reported to the board for oversight on a monthly basis.

In relation to open disclosure 4 out of 6 care staff were able to explain the concept of open disclosure, including offering apologies and being transparent about what occurred when mistakes and/or incidents happen.

In relation to restrictive practices, management advised and a review of the clinical governance meeting minutes showed, that restrictive practices are monitored by the clinical leadership team and reported to the facility manager via clinical indicator reporting. Management said that the board is informed of the use of restrictive practices as they receive a monthly report with clinical indicators and said it is regularly discussed in the medication advisory committee meeting and clinical governance committee meeting which was reflected in the minutes for both meetings. However, management advised registered nurses currently have to review progress notes to monitor PRN psychotropic medication use as the service’s electronic care management system does not have the capacity to flag this, which can lead to gaps in information on PRN administration.

In their response to the Assessment Team report the approved provider outlined several improvements it will make to monitor restrictive practices, including administration of PRN psychotropic medication and working towards deprescribing it where possible. The improvements will include reviewing the psychotropic register after weekly rounds by the medical officer and regular consultation with the onsite pharmacist.

I commend the improvements the approved provider has committed to in order to return to compliance in this requirement. However, I consider it will take time for these improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 8(3)(e) non-compliant.

**Compliant Requirements**

Requirement 8(3)(a)

The Assessment Team found the service demonstrated consumers and representatives are actively engaged in the development, delivery and evaluation of care and services. Consumers and representatives confirmed they were able to provide feedback to the service and advised they regularly participate in consumer representative meetings. Some consumers noted they were members of the consumer advisory committee that is also attended by the board, where they discuss feedback from consumers and improvements required to enhance quality of care and services. The Assessment Team reviewed meeting minutes from consumer meetings, board meetings, progress notes from consumer of the day, care plan evaluations, and results from consumer and representative experience surveys, all of which evidenced consumers are encouraged and supported to be actively engaged in the development, delivery and evaluation of care and services.

Requirement 8(3)(b)

The Assessment Team found the service demonstrated it is supported by the governing body to deliver safe, inclusive, and quality care and services. Management described how the service self-monitors its performance against the Quality Standards through internal audits, benchmarking, and monthly quality reports which are sent to the board for discussion during monthly meetings. The Assessment Team reviewed board meeting minutes dated 30 November 2023, and clinical governance meeting minutes dated 22 March 2024 that showed compliance with the Quality Standards, legislative compliance and consumer input were all items that were discussed. The board includes members that are clinically experienced and executive and non-executive members. Management described how feedback from consumers and representatives encouraged the Board to improve the environmental features of the service which included repainting the service’s roof just before Christmas in December 2023.

Requirement 8(3)(c)

This Requirement was found non-compliant following an Assessment Contact from 14 November 2023 to 16 November 2023. The service was unable to demonstrate that they were meeting their regulatory requirements in relation to reporting SIRS incidents and in relation to implementation and effective use of their clinical information management system.

During the current site audit conducted from 4 June to 6 June 2024 the Assessment Team found the service had implemented actions to address the identified areas of non-compliance. The service had trained all clinical staff and management on how to use the electronic consumer management system, including how to update care plans. Management received SIRS refresher training. The service was in the process of reviewing all SIRS incidents from 2023 and ensuring they were reported to the Commission

The Assessment Team found the service demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, and feedback and complaints. However, the service did not demonstrate effective workforce governance and regulatory compliance.

Information management

The Assessment Team found the services information management systems were effective and fit for purpose. Management and staff said they can easily access the information they need to perform their roles on the electronic management system, as well as documents in nurses stations. They can access policies, procedures and training through an online portal. However, management noted consumers’ BGLs were not being recorded on electronic care management or medication management systems. However, I have considered this in Requirement 3(3)(a). Also, the Assessment Team found there were gaps in the recording of PRN medication use on the electronic management system to alert clinical management. However, I have considered this in Requirement 8(3)(e).

Continuous improvement

The assessment Team found the service’s plan for continuous improvement outlined entries from various sources such as audits, surveys, and feedback and complaints from consumers, representatives, and staff. Management described how the service identifies opportunities for continuous improvement through internal audits, clinical indicators, incident reports, feedback and complaints from consumers representatives and staff, consumer meetings, and day-to-day observations.

I note the approved provider supplied a comprehensive plan for continuous improvement in its response to the Assessment Team report that addresses the key areas of identified non-compliance.

Financial governance

The Assessment Team found the service has effective financial governance systems and processes. Management advised they are supported by the board to make purchases to improve the service and they have not experienced issues in seeking financial approval from the governing body when needed. They said that the board supports funding for additional staffing and equipment to ensure that quality care and services for consumers is prioritised.

Feedback and complaints

The Assessment Team found the service has effective feedback and complaints systems and processes. Management described how the governing body has an overview of the feedback and complaints through regular reports from the service. Management stated that feedback and complaints are discussed in staff meetings and are monitored by the quality assurance team to identify trends and opportunities for further improvement. Two consumers noted dissatisfaction regarding the resolution of their complaints. I have considered this in Requirement 6(3)(c).

Workforce governance

The Assessment Team found the service did not demonstrate effective workforce governance. The organisation has a system for recruitment and management of staff with defined skills and competencies. Management described how the workforce are continuously reviewed to ensure staff can deliver quality care and services. However, staff and some consumers advised there were insufficient staff to provide timely care and services. I have considered this in Requirement 7(3)(a) and was not satisfied there was sufficient evidence to support this feedback.

Regulatory compliance

The Assessment Team found the service did not have effective governance systems and processes in place in relation to regulatory compliance. The Assessment Team observed various service-level and organisational-level meeting minutes and standing agendas that included regulatory compliance updates on legislative requirements. Updates from head office are distributed to staff and there is an online policy and procedural platform that automatically updates the quality team of legislative changes. The Assessment Team report noted there were some SIRS incidents the service did not report to the Commission within required regulatory timeframes. However, I have considered this in Requirement 8(3)(d).

Having considered the Assessment Team report I am not satisfied there is sufficient evidence of non-compliance in relation to workforce governance and regulatory compliance, as I have already considered the evidence raised in this requirement, in Requirements 7(3)(a) and 8(3)(d) respectively. I consider the other sub-requirements are compliant. Accordingly, I find Requirement 8(3)(c) compliant.

Based on the information summarised above, I find the service compliant in Requirements 8(3)(a), 8(3)(b) and 8(3)(c).

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