Performance

Report

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| Name of service: | Laurieton Lakeside Aged Care Residence |
| Service address: | 349 Ocean Drive LAURIETON NSW 2443 |
| Commission ID: | 2793 |
| Approved provider: | Halenvy Pty Limited |
| Activity type: | Site Audit |
| Activity date: | 12 December 2022 to 14 December 2022 |
| Performance report date: | 27 February 2023 |

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 K. Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site audit, the Site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives.
* the provider’s response to the assessment team’s report received 25 January 2023.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

Requirement 2(3)(a) - The Approved Provider ensures assessment and planning appropriately considers risks to consumers and is used to inform care and services.

Requirement 2(3)(b) - The Approved Provider ensures each consumer’s current needs, goals and preferences are identified and assessed, including end of life planning.

Requirement 2(3)(c) - The Approved Provider ensures consumers and others the consumer wishes to involve are included in the assessment and planning processes and other organisations and providers are included appropriately.

Requirement 2(3)(d) - The Approved Provider ensures the outcomes of assessment and planning are communicated to consumers and documented in a care and services plan, that is readily available to the consumer.

Requirement 2(3)(e) - The Approved Provider ensures care and services are reviewed regularly, and when circumstances change or when incidents occur that impact on the needs, goals or preferences of the consumer.

Requirement 3(3)(a) - The Approved Provider ensures each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that

Requirement 3(3)(b) - The Approved Provider ensures effective management of high impact or high prevalence risks associated with the care of each consumer.

Requirement 3(3)(d) - The Approved Provider ensures 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) - The Approved Provider ensures 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) - The Approved Provider ensures timely and appropriate referrals to individuals, other organisations and providers of other care and services.

Requirement 4(3)(d) – The Approved Provider ensures information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

Requirement 7(3)(c) - The Approved Provider ensures staff have the knowledge through staff training and support to effectively perform their roles.

Requirement 8(3)(b) - The Approved Provider ensures the governing body promotes a culture of safe, quality and inclusive care and remains accountable in its delivery.

Requirement 8(3)(c) - The Approved Provider ensures effective organisation wide governance systems relating to information management and regulatory compliance.

Requirement 8(3)(d) – The Approved Provider ensures it has effective risk management systems and practices in place to manage high impact and high prevalence risks to consumers, including the use of an effective incident management system.

# 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

Following a Site Audit from 01 to 03 June 2021, the service was found non-compliant in Requirement 1(3)(a). Evidence brought forward in the site audit report dated 12 to 14 December 2022 supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with this Requirement.

Requirement 1(3)(a)

Consumers and representatives stated staff are kind and respectful and treat them with dignity when speaking and attending to them. Staff were observed interacting with consumers in a kind and respectful manner and described consumers' individual care needs. The improved care planning process is transitioning from paper-based to an electronic care management system and evidenced information is stored to support staff’s knowledge and understanding of consumers' care needs and preferences.

Regarding the remaining requirements of Quality Standard 1:

Consumers and representatives confirmed that consumers' cultures are respected, and their preferences help to inform culturally safe care needs. Staff described consumers' cultural, religious, and personal preferences and how they inform their care needs. Care documentation reflected the consumers' cultural needs and preferences.

Consumers and representatives said consumers feel supported to exercise choice and independence around making decisions, making connections, and maintaining relationships. Staff described how consumers' choices and decision-making are supported through the care planning process and care planning documentation evidenced consumers' life stories, backgrounds, and people of importance to them are documented. Consumers were observed engaging with each other and visitors.

Consumers and representatives said they are supported to live their best lives. Staff explained the steps to mitigate the risks for consumers including undertaking risk assessments, continuously monitoring the consumer, and completing the required dignity of risk and assessment based on the type of risk. Care planning documentation reflected discussions held with consumers and representatives regarding risks, potential harm, mitigating strategies to support consumers' choice.

Consumers and representatives stated they receive current, accurate and timely information; representatives said they receive general and COVID-19 updates as well as communication about any changes and consumers said they get regular updates on the monthly activities calendar, and daily meal options. Staff described keeping representatives informed on incidents relating to consumers, information is distributed through monthly meetings, newsletters, and minutes; menus were observed displayed in the various dining areas and the activity calendar located in consumers' rooms.

Consumers and representatives said consumer privacy was respected and information was kept confidential. Staff described how they maintain consumers’ privacy when providing care, especially with shared rooms, information is kept private and confidential in locked nursing stations and password protected computers. Staff were observed knocking on consumers' doors and closing doors and curtains behind them when attending to care needs.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

Following a Site Audit from 1 to 3 June 2021, the service was found non-compliant in Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d), 2(3)(e).

Evidence in the site audit report dated 12 to 14 December 2022 demonstrates the service is implementing improvements to address areas of non-compliance, however, these improvements have not been adequate or effective and I find the Service non-compliant with all five Requirements, I have provided evidence and reasoning below.

Requirement 2(3)(a)

The service was previously unable to demonstrate effective assessment and management processes to identify and manage risks for consumers, particularly in relation to complex care needs such as behaviours, skin integrity and chemical restrictive practices.

During the site audit of December 2022, the Assessment Team found that documentation did not reflect that consumers’ risks had been clearly identified and documented to inform the delivery of safe and effective care. Specifically, the Assessment Team identified ongoing deficits in the management of behaviours and management of risks associated with restrictive practices, skin integrity and incident management.

The Assessment Team brought forward the following evidence;

One named consumer’s representative who stated they experienced a general lack of communication from the service. A review of this consumer’s care documentation identified risks to the consumer in relation to hydration, however the care plan had not been updated since October 2022 and no documented evidence that the service had managed these risks.

A further named consumer’s representatives advised there had not been recent consultation with them and they were not made aware of recent skin injuries sustained by the consumer. A review of this consumers care documentation found that the service had identified potential risks and injuries to skin in October 2022, however there was no evidence of an incident report, no update to the skin care plan and no evidence of pain monitoring in response to these risks.

The care plan for a third named consumer with mobility difficulties, who is unable to hold cutlery was found by the Assessment Team to have been assessed by the service as only requiring ‘supervision during mealtimes.’ The Assessment Team further identified in care documents that this consumer experienced knee pain in October 2022 and was administered medication to address these issues. There was no evidence of pain monitoring following this incident, and care records demonstrated that the service trailed alternative medications, without consultation with the consumer or their representative. A further risk plan updated in November 2022 did not detail the use of alternative medications, nor the risks associated with its use.

On 25 January 2023, the Approved Provider submitted a written response, including a Plan for Continuous Improvement (PCI). The Approved Provider advised that prior to the Site Audit the service had sought external guidance and support to implement actions to address the ongoing deficits. The Approved Provider acknowledged the ongoing deficits in care documentation identifying the use of multiple systems as a root cause of misaligned consumer care documentation.

In response to the deficits in risk assessments identified by the Assessment Team, the Approved Provider explained that information relating to individualised consumer risk assessments was completed in hard copy format and stored at each nurse’s station. The Approved Provider submitted evidence in relation to the named consumers of hard copy risk assessments that were in place prior to the Site Audit. The service intends to implement new software to consolidate assessment and planning processes and documentation with the rollout staff education and training and cessation of paper-based process to be implemented by February 2023.

The Approved Provider further undertook to implement a Resident of the Day process, ongoing monthly assessments and four monthly care plan reviews and monthly contact with representatives. The Approved provider plans for staff education and resources for the Resident of the Day process to be fully implemented by 2 March 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its response. While I acknowledge the additional hard copy evidence of risk assessments that were undertaken prior to the Site Audit, I have also given weight to the fact that some of these assessments do not address some of the risks identified by the Assessment Team. I have also considered that the planned actions of the Approved Provider, such as the implementation of new systems and processes and staff education and training will take time to embed and measure for effect. Based on the evidence available to me, I am not satisfied that the Approved Provider has demonstrated effective assessment and planning processes. I find Requirement 2(3)(a) non-compliant.

Requirement 2(3)(b)

During the Site Audit on 12 to 14 December 2022, the documents reviewed by the Assessment Team had ongoing deficits in relation to ensuring that assessment and planning identifies and addresses consumer’s current needs, goals, and preferences. Most of the consumer files reviewed did not have up to date care plans in place, with some not having a full complement of care plan suite in place and those that were reviewed not appropriately capturing current needs, goals and preferences of consumers. Representatives also expressed their dissatisfaction in relation to the consultation process to discuss the needs, goals, and preferences of consumers. The Assessment Team noted that all sampled consumers had complete advance care directives in place.

The Assessment Team brought forward evidence of two named consumers who had expressed preferences or assessed as requiring care to be delivered by specific genders of staff. During the site audit the Assessment Team observed care not being delivered in accordance with these needs or preferences and spoke with staff who did not have a shared understanding of these requirements.

In its written response of 25 January 2023, the Approved Provider acknowledged the gaps in the documenting assessment and care plans. The Approved Provider provided evidence that care preferences had been circulated to staff in the form of a hard copy memorandum in October of 2022, however, notes that the use of agency and furloughed staff contributed to these preferences not being adhered to. The Approved Provider further identified recent outbreaks and staff furloughing had impacted care plans being updated with current needs and preferences.

I have considered the evidence brought forward by the Assessment Team and the additional evidence provided by the Approved Provider. While I accept the improvements currently being rolled out by the Approved Provider, such as an electronic care system to consolidate documentation and support assessment planning, I have also considered the ongoing impacts to consumers observed by the Assessment Team and the anticipated time it will take to establish electronic systems and staff training. On the balance of evidence available, I find Requirement 2(3)(b) non-compliant.

Requirement 2(3)(c)

The service was unable to demonstrate that consumers with complex care needs including behaviours and subject to chemical restrictive practices were managed effectively as care planning documentation did not reflect the involvement of allied health providers and other support organisations to seek alternative interventions for consumers displaying behaviours prior to using chemical restrictive practices. While management confirmed that referrals for consumers were being sought by the service, the clinical files reviewed did not demonstrate adequate evidence of timely and appropriate multidisciplinary care approach from other providers of care.

The Assessment Team brought forward evidence of two named consumers whose care plans were reviewed, one named consumer who was identified with choking risks and non – insulin dependent diabetes whose nutrition and hydration plan, last reviewed in May 2022 did not reflect recommendations from a speech pathologist, nor the involvement or referral to a dietician and a further named consumer with additional behavioural support needs that were not being effectively managed or supported by the service as staff were unaware of strategies to manage behaviours. The representatives for both consumers raised concerns with the Assessment Team about a general lack of communication and consultation from the service in relation to how care is planned and managed for these consumers.

In its response of 25 January 2023, the Approved Provider advised that the service relies on both internal and external multidisciplinary teams including, physiotherapists, occupational therapists, dietician, speech pathologist and podiatrist among other to plan and deliver appropriate care to consumers. The Approved Provided further stated that behaviour support is sought through a psychogeriatric team for individualised assessment and planning strategies.

Having considered the evidence brought forward by the Assessment team and the Approved Provider in its response, I am not satisfied that the Approved Provider has demonstrated that assessment and planning is built on partnerships with consumers and involves appropriate and involves other individuals and services where necessary. I have placed weight on the feedback from representatives given to the Assessment Team and the gaps in care documentation referral and planning identified by the Assessment Team. I find Requirement 2(3)(c) non-complaint.

Requirement 2(3)(d)

The Assessment Team found that care planning documentation had ongoing deficits in relation to documenting the outcomes of case conferences, or when changes in consumers’ needs occurred, particularly in relation to chemical restraint where changes in psychotropic medications occurred. The Assessment Team spoke with consumers and representatives who minimal involvement in the assessment, planning and review process. Most representatives the Assessment Team spoke to said they have not seen a care plan and did not know they could request a copy. Management acknowledged the ongoing deficits and confirmed that a case conference schedule was planned to commence in 2023 following the implementation of the new electronic case management system.

The Assessment Team brought forward evidence of one named consumer who was subject to restrictive practices who had not been consulted prior to a change in medication. The Assessment Team observed email communication between the service and consumers representative regarding the change in medications, however there was no evidence provided that a detailed description of risks associated with the use of chemical restrictive practice was discussed, nor information outlining when the medication would be administered. The representative advised the Assessment Team that they do not get regular updates regarding the consumers’ care.

The Approved Provider’s response of 25 January 2023 further emphasised that the transition to the electronic management system would address the deficiencies in care plan reviews and consultation by providing all representatives and consumers access to care plans assessments and reviews. The response further stated that the service uses alternate strategies prior to the use of psychotropic medications and staff are supported by a behaviour management procedure prior to restraint interventions.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its response. I acknowledge the implementation of the electronic care management system intends to provide better tools for engagement with consumers and representatives, however I also note the system has not been fully implemented to date and staff training, and adoption of processes will take time to embed and effect change. I have also considered the feedback from representatives and consumers and their ongoing impacts while these systems are rolled out. Based on the evidence available to me, I find Requirement 2(3)(d) non-compliant.

Requirement 2(3)(e)

Ongoing deficits were identified in relation to the lack of regular review of care and services including when incidents occur. Documents reviewed by the Assessment Team had ongoing deficits in relation to timely and appropriate reporting of consumer incidents, as well as processes in relation to assessment and care plan updates, following a consumer incident. Staff did not demonstrate adequate understanding of the service’s incident management processes stating that not all consumer injuries are reported via incident reports, unless an injury is sustained following a consumer’s fall. During the site audit, management advised that further education and staff training is planned on reporting obligations and a full consumer review will be undertaken as part of the electronic care management system transition.

The Assessment Team brought forward evidence relating to a named consumer identified with a skin injury following an incident the Assessment Team identified as occurring in November 2022. The Assessment Team reviewed documentation for an occupational therapist that stated the mobilisation equipment used for said consumer was inadequate, potentially contributing to pressure injuries. The Assessment Team noted that no progress notes or follow up occurred following this incident.

In its written response of 25 January 2023, the Approved Provider acknowledged the previous practice of reporting incidents, such as skin tears in the wound management system was impacted due to an inability to provide staff training in the preceding year. The Approved Provider advised that upcoming training with the implementation of the new care management system would address the gaps. In response to the evidence brought forward by the Assessment Team in relation to the named consumer, the Approved Provider submitted further explanation that this was not considered an incident as identified by the Assessment team, however acknowledged the circumstances should have been considered a near miss and recorded in the incident register.

Having considered the evidence brought forward by the Assessment Team and the Approved Provider, I have accepted the additional explanation made by the Approved Provider in relation to the named consumer. However, I have also considered the evidence brought forward relating to the knowledge deficiencies of staff in understanding and reporting incidents and the planned actions to overcome these that include staff training and the implementation of new systems and processes that will take time to embed and measure for effect. Based on the totality of this evidence, I find Requirement 2(3)(e) non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-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

Following a Site Audit from 01 to 03 June 2021, the service was found non-compliant in Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), 3(3)(f). Evidence in the site audit report dated 12 to 14 December 2022 demonstrates the service is implementing improvements to address areas of non-compliance, however, these improvements have not been adequate or effective and I find the Service non-compliant with these Requirements, I have provided evidence and reasoning below.

Requirement 3(3)(a)

The service was previously unable to demonstrate effective care management processes for key areas of clinical care including for restrictive practices, skin integrity and pressure injuries, pain and wound care, and staff were not familiar with relevant policies and procedures such as routinely monitoring consumers for pain where changes have occurred in their condition.

During the site audit of December 2022, The Assessment Team found that care planning documentation did not reflect ongoing monitoring and management of key areas of clinical need for individual consumers, particularly those with complex care needs, this included for behaviours, restrictive practices, diabetes, nutrition and continence, pain management, wound care and skin integrity.

The Assessment Team brought forward the following evidence:

For one named consumer with multiple complex diagnoses including type 2 diabetes, no diabetic care plan was in place nor were any individualised signs and symptoms documented together with strategies for managing the consumers’ blood glucose levels. Progress notes and clinical records showed significant gaps in consistent monitoring of the consumers’ blood sugar levels.

For a further named consumer, deficits were found related to the management of the consumers’ behaviours, chemical restrictive practices, skin integrity, pain and continence care. The representative said the service did not meet the consumers’ overall care needs, they had not consented to the use of psychotropic medication for the management of the consumers’ behaviours and the service does not respond to the consumers’ behaviours appropriately. Care planning documentation provided limited information on managing chemical restrictive practices, particularly in relation to alternative support interventions prior to using medication; no signed consent for use of chemical restrictive practices was in place. The communication care plan reflected that yelling is a form of communication for this consumer due to their cognitive decline however staff were observed ignoring the consumer and not attending to their repeated yelling, staff confirmed they did not recognise this to be a form of communication as detailed in the communication care plan.

Care planning documentation for a third named consumer, evidenced that the consumer was not receiving best practice care for a range of complex care needs including for diabetes, pain and wounds, behaviours, continence and catheter care. Recommendations from allied health professionals were not referenced in care plans to inform staff of the consumers individual’s needs. The representative was not aware of recent changes to the consumers health status and had not been consulted regarding updates to the care plan. Staff had limited understanding of the consumers’ complex care needs including of risks associated with providing complex consumer care.

On 25 January 2023, the Approved Provider submitted a written response, including a Plan for Continuous Improvement (PCI) and advised that prior to the Site Audit, the service had sought external guidance and support to implement actions to address the ongoing deficits. The Approved Provider acknowledged the ongoing deficits in care documentation identifying the use of multiple systems as a root cause of misaligned consumer care documentation.

In response to the deficits in the provision of clinical care and services identified by the Assessment Team, the Approved Provider advised a number of corrective actions have commenced including a review of the restrictive practice policy and procedure, updating and reviewing the restrictive practice register to include dates of authorisation and approval by the consumer and representative and staff education on key areas of clinical care has been introduced. The service intends to implement an integrated electronic care management system to consolidate clinical monitoring processes and documentation with the rollout staff education and training and cessation of paper-based process to be implemented by February 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its response. While I acknowledge the corrective actions taken to address non-compliance identified in the site audit report, I consider that the planned actions of the Approved Provider, such as the implementation of new systems and processes and staff education and training will take time to embed and measure for effect and I have given weight to the impacts to consumers while these processes are embedded. Based on the evidence available to me, I find Requirement 3(3)(a) non-compliant.

Requirement 3(3)(b)

The service was previously unable to demonstrate the effective management of consumers with high impact or high prevalence risks; deficits related to managing consumers with behaviours, and a post falls incident involving a consumer sustaining a head strike without a neurological observation completed and the management of medication outside of the service’s policies.

During the Site Audit on 12 to 14 December 2022, care planning documentation evidenced gaps in identifying, monitoring, and recording consumer risks, as well as completing observations post fall. Risks associated with the use of restrictive practices, behavioural risks, falls risks, and skin integrity risks were not clearly referenced in care planning documentation, one consumer had not been reviewed despite repeated complaints of adverse reaction to the use of the psychotropic medication. Deficits in catheter management and blood glucose monitoring were identified in care plans.

The Assessment Team brought forward evidence of three named consumers whose risks had not been managed appropriately.

One named consumer had experienced a fall and sustained a laceration to their head, however, clinical documentation demonstrated inconsistent vital observation and monitoring of the consumer post fall, care plans had not been updated to reflect the incident and laceration sustained and no pain charting was evident. The consumers’ risk mitigation care plan did not reflect the consumers’ updated falls risk following the recent incident.

For a further named consumer subject to chemical restrictive practice their emotional support care plan references psychotropic medication to support behaviours however, no directives are provided to ensure pharmacological interventions are used as a last resort. Risks had not been identified, no alternative strategies had been identified and no consent form was recorded. Staff were observed not to attend to the consumers’ behaviours of yelling and did not check on their wellbeing or care needs. The consumer’s communication care plan indicated the consumer will yell out when communicating something is wrong however staff did not refer to this directive nor demonstrated awareness of this.

For a third named consumer assessed as immobile, at high falls risk and with complex care needs relating to pain and wound management, care planning documentation evidenced gaps in care plans and monitoring and charting of specific areas of clinical care including for diabetes, pain and wounds and behaviours, Additionally, recommendations such as strategies for managing episodes of choking and the use of heel protection to prevent wounds from allied health professionals including the speech pathologist and occupational therapist had not been included in various care plans. In relation to the effective management of pain and wounds, the service did not assess nor provide non-pharmacological interventions prior to initiating nurse-initiated analgesia. The representative was not aware of recent injuries sustained by the consumer and had not been consulted regarding updates to the care plan. Staff had limited understanding of the consumers’ complex care needs and were not aware of risks associated with various aspects of consumer care.

In the Approved Provider’s written response of 25 January 2023, the Provider acknowledges the ongoing deficits in care planning documentation which they consider stems from fragmented clinical documentation between three systems which is currently being transitioned into an integrated electronic care management system with a due date for completion of February 2023. Additionally copies of signed consumer choice, risk and dignity forms and emailed correspondence with representatives were submitted by the Approved Provider.

For all named consumers, the service has implemented a manual system of documenting and assessing consumer risk. Information pertaining to individual consumer risks is now stored in the nurses’ station and addresses issues such as living with challenging behaviours, skin integrity issues, complex care needs, dignity of choice, falls risk and the use of psychotropic medications and staff training has commenced on the new electronic care management system.

For all named consumers, the Approved Provider acknowledged deficits in recording and reporting identified incidents, and additional information submitted included incidents forms, policy excerpts, progress notes, review notes from allied health providers to demonstrate that the service is managing risk for some consumers effectively.

To address the deficits regarding restrictive practices and behaviour management, the Approved Provider provided evidence to show consumers are attended to daily by a multi-disciplinary team for a range of services including government disability support services, occupational therapy, physiotherapy, speech pathology, and occupational therapy and massage. Additionally, consumers are monitored for pain by clinical staff with 7-day pain charts.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its response. I have accepted the additional evidence provided by the Approved Provider, demonstrates improvements to the established risk management processes, however I have also given weight to the fact that not all risks were being clearly identified and effectively managed by the service and planned actions such as implementation of the new electronic care management systems and processes and staff education and training to support its use, will take time to embed and measure for effect. Based on the evidence available to me. I find Requirement 3(3)(b) non-compliant.

Requirement 3(3)(d)

Ongoing deficits were reported by the Assessment Team in relation to the timely identification, monitoring, and recording of changes or deterioration of consumers mental health, cognitive or physical function or condition.

The site audit report brought forward information for one named consumer experiencing behaviours, and skin integrity issues, whose care planning documentation did not have sufficient information recorded to ensure care delivery to address consumer deterioration. Management acknowledged ongoing deficits in relation to responding to increasing behaviours of a named consumer and staff described how the consumer is supported for periods of time by an external government support agency which is effective in managing the consumers’ escalating behaviours when available, however the service does not have capacity to always offer one on one support when no external agency staff are available. Overall, the service could not demonstrate proportionate and adequate response to the consumers’ escalating behaviours resulting in the consumer being left unattended for long periods of time.

In the Approved Provider written response of 25 January 2023, the Provider acknowledged the deficits in documentation to evidence the service recognises and responds to changes in consumers condition particular for one named consumer experiencing escalating behaviours. Additional documentation and information were submitted by the Approved Provider to demonstrate improvements to address identified non-compliance including itemised improvements detailed in the plan for continuous improvement such as arranging for all consumers with dementia to be reviewed by an external dementia specialist organisation, as well as pain reviews and positive behaviour support plans and emotional care support strategies to be developed. The Approved Provider advised that upcoming training with the implementation of the new care management system would address the gaps.

Having considered the evidence brought forward by the Assessment Team and the Approved Provider, I have accepted the additional explanation made by the Approved Provider in relation to the named consumer. However, I have also considered the evidence brought forward relating to inconsistencies in documenting response actions to changes and a lack of understanding amongst staff in relation to appropriate response actions to escalating behaviours. Improvements to overcome deficits include staff training and the implementation of new electronic systems and processes however, I consider that it will take time to embed and measure improvements for effect. Based on the totality of this evidence, I find Requirement 3(3)(d) non-compliant.

Requirement 3(3)(e)

Consumer information contained in care planning documentation was observed to be fragmented, incomplete and inconsistently stored across various systems; for some consumers with complex care needs, clinical documentation did not include directives for pain management, behaviour management, sleep and rest management, as well as catheter care and continence management. Care planning documentation was observed to be contradictory in one instance and stored in various systems covering falls risks, mobility needs and care directives, documentation generally did not contain updated care delivery strategies following identified changes in care needs, the chemical restraint register did not reflect current information, had gaps in consent and review dates.

The Approved Provider submitted additional information confirming that the service is transitioning three care management systems into one and were aware of resulting ongoing deficits in relation to inadequate recording of consumer’s condition, needs and preferences to ensure information is shared effectively with others where responsibility for care is shared. The Approved Provider outlined numerous ways in which the service regularly communicates with representatives but concedes that communication has been impacted by COVID-19 outbreaks and other challenges.

Having considered the evidence brought forward by the Assessment Team and the Approved Provider, I acknowledge the planned and commenced actions made by the Approved Provider in relation ongoing transitions to an integrated electronic care management system and other improvements to overcome identified deficits however, I consider the integration of these systems is ongoing and additional supports such as changed processes and staff training are still being rolled out and will take time to implement. Based on the totality of this evidence, I find Requirement 3(3)(e) non-compliant.

Requirement 3(3)(f)

Care planning documentation did not evidence recent referrals for consumers, particularly for consumers with ongoing behavioural needs and choking risks. Whilst staff were familiar with government support services involved caring for consumers, a review of clinical documentation did not reflect the recommendations or appropriate diagnoses when referrals had occurred.

The Assessment Team spoke with management who confirmed that referrals for consumers were being sought by the service, however the clinical files reviewed did not demonstrate adequate evidence of timely and appropriate multidisciplinary care approach from other providers of care.

In its response of 25 January 2023, the Approved Provider advised that the service relies on both internal and external multidisciplinary teams including physiotherapists, occupational therapists among others to plan and deliver appropriate care to consumers. The Approved Provided further stated that behaviour support is sought through a psychogeriatric team for individualised assessment and planning strategies.

Having considered the evidence brought forward by the Assessment team and the Approved Provider in its response, I am not satisfied that the Approved Provider has demonstrated that consumers get timely and appropriate referrals to individuals and other providers of care where necessary. I have given weight to the evidence brought forward by the Assessment Team regarding the lack of documentation and evidence to support these referrals are occurring in a timely manner and the resulting impact to consumers. I find Requirement 3(3)(f) non-complaint.

Regarding the remaining requirement of Quality Standard 3:

Care planning documentation evidenced information about the consumer’s condition, needs and preferences is documented and communicated within the service through the development of palliative care plans. The representative of a consumer who has undergone an end-of-life pathway confirmed their satisfaction with the care and services provided to the consumer, particularly in the last stages of the consumer’s life. Staff described the care delivery required for consumers undergoing end-of-life pathway. The service continues to review its’ policies and procedures, in relation to end-of-life care.

Consumers and representatives said the service managed COVID-19 precautions and other infection control practices effectively and staff confirmed they have received training in infection minimisation strategies including infection control and COVID-19. Staff demonstrated an understanding of precautions to prevent and control infection and the steps they could take to minimise the need for antibiotics. The service has a staff and consumer vaccination program and records are maintained for influenza and COVID-19 vaccination. The service has an outbreak management plan to manage infectious outbreaks, including COVID-19.

# 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. | Non-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

Following a Site Audit from 01 to 03 June 2021, the service was found non-compliant in Requirement 4(3)(d). Evidence in the site audit report dated 12 to 14 December 2022 demonstrates the service is implementing improvements to address areas of non-compliance, however, these improvements have not been adequate or effective and I find the Service non-compliant with this Requirement, I have provided evidence and reasoning below.

Requirement 4(3)(d)

The Assessment Team found some improvements in how the service communicates information about consumers both internally and externally. Improvements such as the transition from paper- based to electronic documentation and more thorough handover documentation supported the sharing of consumer information and lifestyle staff had developed detailed plans and activity charting processes.

However, the Assessment team found some ongoing deficits, including one named consumer who preferred female assisted care who stated they received care from both male and female staff, when raised with staff they were unaware of this preference, despite this information being recorded in the care plan.

The Assessment Team further observed that staff continue to rely heavily on the verbal sharing of information during handovers and similar interactions to guide their understanding of consumer’s care needs and preferences.

In the written response of 25 January 2023, the Approved Provider acknowledged the evidence brought forward by the Assessment Team and advised that it is confident the full implementation of a new electronic care management system resolve these issues. Concurrent with the implementation of the new system, the Approved Provider has planned additional staff training and education to establish new processes and user specific training to prompt planning and care delivery, which will support information sharing. This further training is due for delivery and implementation by 28 February 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider’s response, I acknowledge that the introduction of the new care management system will provide greater transparency and support information sharing amongst staff. However, I have also considered that the adoption of processes and training of staff will take time to embed and affect change and have given weight to the impacts to consumers while this occurs. Based on the evidence available to me, I find Requirement 4(3)(d) non-compliant.

Regarding the remaining requirement of Quality Standard 4:

Consumers stated that services and supports for daily living met their needs, goals, and preferences. Consumers were supported to maintain their independence, well-being, and quality of life. Staff are aware of consumers' interests, and care planning documentation identifies each consumer's needs, goals, and preferences. The Assessment Team observed consumers engaging in group and individual activities in their room according to their preferences, needs and choice.

Consumers and representatives described the service as supportive and promoting each consumer's emotional, spiritual, and psychological well-being. Staff provided examples of how they support consumers' emotional and psychological well-being. Care planning documentation recorded consumers' individual emotional support strategies and how these are implemented.

The service supports consumers in participating in activities both within the service and the external community. Consumers said they could be involved in activities of interest and are supported to maintain relationships of their choosing. Care planning documents contain information about consumers' interests, and staff demonstrated knowledge of individual consumer's preferences. The Assessment Team observed consumers moving around the service, leaving the service with visitors, engaging with each other and visitors, and enjoying various seating areas around the service.

The service demonstrated improvements in the referrals being provided to consumers to other organisations, individuals and providers of other care and services supporting the consumer's daily living. Consumers and representatives said that if the service could not provide the support they needed, they would be confident that they would be referred to an appropriate provider.

Consumers and representatives sampled said the quality of food provided is generally good and that they are provided with a variety of suitable quality and quantity meals. The service has in-house food services assistance and meals are prepared fresh daily, with the exception of pureed meals which are bought locally. The service changes its menu twice a year and is on a monthly rotation. The kitchen has up-to-date dietary requirements indicating each consumer's dietary needs. Dietary listings are also retained in each kitchenette and on the tea trolleys to support consumers' diet needs and preferences. The Assessment Team observed consumers receiving meals in accordance with their preferences.

Consumers and representatives stated that they felt safe and at home at the service and believed the equipment used by staff was clean, suitable, and well-maintained to support their needs. Consumers and staff stated that any equipment repairs are completed by maintenance, and they felt comfortable raising maintenance requests and believed it to be completed in a timely manner and to satisfactory standards. Shared equipment is stored in designated areas and cleaned by staff before and after use. The Assessment Team observed mobility aids being used by consumers, and shared equipment such as shower chairs and lifting equipment being used, cleaned, and suitable for consumers' needs. The service maintains a preventative maintenance schedule, indicating maintenance to be performed throughout the year by in-house and/or external contractors.

# 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

The service provides a range of communal spaces, both indoors and outside courtyards which are comfortably furnished, clean and free of clutter. Consumers and representatives stated they were satisfied the environment was inviting and welcoming. Consumers were observed independently accessing different areas of the service enabling interactions with co-consumers. Consumer rooms were observed to be personalised to their choice.

The service was observed to be safe, clean, and well-maintained. Consumers and representatives stated they felt comfortable and were satisfied with the cleaning and maintenance at the service. Staff described cleaning and maintenance practices at the service including how to report maintenance issues to be corrected. Consumers were observed moving around freely, accessing different areas such as seating areas, the café, the hairdresser, courtyards, and smoking areas. Cleaning schedules demonstrated daily, and spring cleaning was undertaken, monitored, and reviewed.

Consumers and representatives indicated that furniture, fittings, and equipment are clean, safe, and well-maintained and supports their needs and capabilities. Staff indicated they have access to the necessary equipment to support the consumers safely and effectively. Maintenance described the processes to ensure furniture, fittings, and equipment are safe, clean, and well maintained. Furniture and equipment were observed in use to support consumers' needs.

# 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

Following a Site Audit in June 2021, the service was found non-compliant in Requirements 6(3)(a), 6(3)(b), 6(3)(c) and 6(3)(d). Evidence brought forward in the site audit report dated 12 to 14 December 2022, supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with these Requirements.

Requirement 6(3)(a)

Consumers and representatives stated they are now encouraged and assisted to make complaints and provide feedback. Staff confirmed they assist consumer and representatives with complaints/requests and follow-up to ensure resolutions are put in place. Information on raising complaints was contained in the services’ welcome pack, consumer handbook and service contracts. The service has introduced a complaints log and incident register, which evidenced complaints and feedback, and resolutions are recorded and monitored.

Requirement 6(3)(b)

Consumers and representatives confirmed they are aware of advocates, language services and other methods for raising and resolving complaints. Staff described other complaints mechanisms such as through advocacy organisations and the availability of translation services, Comprehensive information is now included in the welcome pack for new consumers, which was observed to contain brochures for a wide range of advocacy bodies and information for language services.

Requirement 6(3)(c)

Representatives stated they are promptly informed if there are any issues and the service takes appropriate action including an open disclosure process, with an apology, if there are issues and adverse effects on consumers. Staff described actions required for recording, escalating, and resolving complaints, including the use of open disclosure. The service has policies and procedures for open disclosure, incident recording and training for staff.

Requirement 6(3)(d)

Consumers and representatives said feedback and complaints are used to improve the quality of care and services. Staff said they attend to complaints promptly and will escalate issues to management for resolution. The service has implemented a formal complaints register that includes an action plan for resolution. The plan for continuous improvement confirmed feedback and complaints have been used to improve the quality of care and services provided to consumers.

# Standard 7

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

Findings

Following a Site Audit in June 2021, the service was found non-compliant in Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(d). Evidence brought forward in the site audit report dated 12 to 14 December 2022, supports the service has implemented improvements to effectively address areas of non-compliance for 7(3)(a), 7(3)(b) and 7(3)(d) and now demonstrates compliance with these Requirements as detailed below.

However, improvements were not effective in addressing deficits for 7(3)(c) and I find the Service non-compliant with this Requirement, I have provided evidence and reasoning below.

Requirement 7(3)(c)

Deficiencies were previously identified in how the service disseminated information among staff with general confusion among staff about the scope of roles and responsibilities, especially in relation to reporting obligations. During the Site Audit in December 2022 the service demonstrated a number of education and training packages had been planned and implemented in relation to role specific clinical training and reporting requirements and mandatory training is now in place as of November 2022 in relation to restrictive practices for staff. Consumers now reported that they felt staff were competent in their roles and they had confidence in the care delivered. However, ongoing deficiencies in clinical knowledge with regard to complex care and a rudimentary understanding of restrictive practices were still evident due to the inability of the service to finalise the implementation of and training in the systems, due to the impact of COVID-19 on staffing numbers and the inability to hold the required face to face training.

While the service had invested in an electronic care management system to consolidate information in one system, the rollout and training of this program had been delayed due to recent outbreaks and resulting impacts to staffing.

In its written response of 25 January 2023, the Approved Provider addressed the deficiencies identified by the Assessment Team, stating that it felt confident that the implementation of the new electronic care management system would resolve the knowledge sharing and information management deficiencies, in relation to the understanding of complex care needs and restrictive practices. In its PCI, the Approved Provider further advised that education for staff concerning restrictive practice management has been planned and will be delivered through the mandatory training calendar between January and March of 2023.

Having considered the evidence brought forward by the Assessment Team in the Site Audit report and the Approved Provider in its response, I acknowledge the improvements made by the Approved Provider to address some of the deficiencies since the last Site Audit, such as additional training and the implementation of a new electronic care management system. I also note the positive consumer feedback in relation to these improvements. However, I have also considered the delay in training for staff on some topics, such as restrictive practices which are not due to be fully implemented for some months and the ongoing impact to consumers until these training packages are delivered. On the balance of this evidence, I find Requirement 7(3)(c) non-compliant.

Regarding the remaining compliant Requirements of Quality Standard 7:

Consumers and representatives said there are now sufficient staff despite some short-term shortages during COVID-19 outbreaks. Management said levels of staff have increased since the resolution of recent COVID-19 outbreaks in November 2022. Staffing numbers and mix have returned to adequate levels and include appropriate numbers of care and clinical staff. Consumer and representative feedback aligned with this evidence and the Assessment team observed adequate staff that were unrushed during the Site Audit.

Consumers and representatives stated staff are kind, caring and respectful of their identity, culture, and diversity. Staff described the ways in which they respect consumers’ rights, uphold their dignity and respect the identity and diversity of each consumer. Staff were observed interacting with consumers in a kind, caring and respectful manner using their preferred name. The service has policies, procedures and training on consumer dignity and choice, cultural diversity, identity, inclusion and training packages relating to consumer dignity and choice have been implemented by the service.

The service has implemented a robust training program including a structured orientation program; toolbox talks; face to face training; competency-based training and a new online portal with relevant subjects including recommendations from previous audits. Training is monitored for completion and staff followed up to complete mandatory modules.

Staff and management were able to demonstrate that assessments, monitoring and review of performance is taking place regularly and that all appraisals are up to date, staff confirmed the appraisal process is beneficial to them. The Assessment Team reviewed staff records that evidenced ongoing performance assessments for staff, both on engagement and then annually.

# 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. | Non-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. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Following a Site Audit in June 2021, the service was found non-compliant in Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). Evidence brought forward in the site audit report dated 12 to 14 December 2022, supports the service has implemented improvements to effectively address areas of non-compliance for 8(3)(a) and 8(3)(e) and now demonstrates compliance with these Requirements as detailed further below.

However, improvements were not effective in addressing deficits for 8(3)(b), 8(3)(c), 8(3)(d) and I find the Service non-compliant with these Requirements, I have provided evidence and reasoning below.

Requirement 8(3)(b)

The Assessment Team identified some improvement implemented by the governing body such as the engagement of specialised nurse consultants to audit and create new care plans for consumers, the development and introduction of policies and procedures to support and guide staff and the implementation of staff training packages. The Approved Provider has established a clinical governance committee that meets regularly and identifies and reports regularly to management and implemented a systemic continuous improvement plan to track and map improvement actions within the service.

However, the Assessment Team identified ongoing deficits in the delivery of care and services, rooted in the slow delivery of the new electronic care management system. The Assessment Team identified ongoing staffing changes at the senior management level and impacts to staff training had impacted the delivery of this system in a timely manner and compromised care and services to consumers.

In its written response of 25 January 2023, the Approved Provider acknowledge some of the issues raised by the Assessment Team such as the impacts to the organisational governance framework. The Approved Provider reiterated recent improvement such as newly appointed staff positions, the engagement of external advisors and the implementation of the electronic care management system that will directly support improvements within the service and pointed to environmental impacts such as weather and ongoing outbreaks in its reasoning that some of the planned improvements had been delayed. The Approved Provider additionally reiterated that it is supported by an established and experienced governing body that will support the service in returning to compliance.

While I acknowledge the challenges experienced by the Approved Provider and acknowledge the issues raised and improvements already undertaken to address the previous non-compliance. I have also considered the delay in some critical improvements such as staff training and the introduction of systems and processes to support staff in the delivery of care and services. On the balance of the evidence available to me, I find Requirement 8(3)(b) non-compliant.

Requirement 8(3)(c)

The Assessment team found the service had appropriate and effective systems in place in relation to continuous improvement, feedback and complaints and workforce and financial governance. The Assessment team identified improvements implemented by the service such as the introduction of a feedback and complaints register and a full suite of human resource processes including clear responsibilities and accountabilities for roles, among others.

However, the Assessment team found that the current information systems in place to manage the care of consumers and disseminate information to staff were insufficient, in most part due to the delay of the introduction of the new electronic care management system and ongoing reliance on paper-based systems.

The Assessment Team also identified deficiencies in the regulatory compliance systems and processes currently established across the service. Specifically, the management of restrictive practices, staff knowledge and understanding of their obligations in relation to restraint management.

The Approved Provider acknowledged the ongoing deficiencies in its written response of 25 January 2023 and advised that ongoing establishment of information technology and associated staff training will be undertaken throughout 2023. Additional staff education and training on restrictive practice management is planned from 1 January 2023 and will from part of mandatory training for staff, due for completion by 1 April 2023.

I have considered the evidence brought forward by the Assessment Team and the additional evidence provided by the Approved Provider. I acknowledge that some actions proposed by the Approved Provider, such as the implementation of information systems are advanced and appropriate to address the issues identified by the Assessment Team, however I consider other actions such as future staff training and the embedding of processes relation to information management and staff training relating to regulatory compliance will take time to embed within the service and its workforce. On the balance of evidence, I find Requirement 8(3)(c) non-compliant.

Requirement 8(3)(d)

The Assessment team found the service was not effectively managing high impact and high prevalence risks and those consumers with complex care needs. The Assessment team identified specific deficits in assessment of risks during planning, an absence of some incidents being appropriately recorded in incident management systems and some gaps in staff knowledge of the appropriate processes for recording and managing risks.

The Approved Provider acknowledge the ongoing deficiencies in its written response of 25 January 2023 and advised that the ongoing establishment of information systems and processes, the establishment of more rigorous, individualised consumer assessments and associated staff training will be undertaken and rolled out throughout early 2023.

I have considered the evidence brought forward by the Assessment Team and the additional evidence provided by the Approved Provider. While I acknowledge the improvements to systems for planning and assessing consumer care, such as the implementation of care management systems, resident of the day processes and additional staff training planned for completion by March 2023, I have also considered the impacts to consumers and while these systems and processes are established and embedded in practice. Based on the totality of this evidence, I find Requirement 8(3)(d) non-compliant.

Regarding the remaining Requirements of Quality Standard 8:

The service has re-established practices to engage consumers and representatives in the development, delivery and evaluation of care and services which are effective in reconnecting consumers and representatives with happenings at the service. Regular consumer and representative meetings enable regular engagement for suggestions and feedback and representatives are frequently emailed information seeking input on improvements at the service.

The service demonstrated an effective clinical governance framework is in place, staff generally knew that chemical restraint was a last resort if non-pharmacological interventions proved to be ineffective over time. Staff interviewed were able to describe antimicrobial stewardship and the strategies to be employed to minimise the use of antibiotics. Open disclosure policies and procedures are in place and practiced and staff could describe open disclosure and the need to provide an apology as part of the process.

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