Macleay Valley House

Performance Report

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Frederickton NSW 2440
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**Commission ID:** 0946

**Provider name:** Thompson Health Care Pty Ltd

**Site Audit date:** 28 March 2022 to 5 April 2022

**Date of Performance Report:** 19 May 2022

# Performance report prepared by

Peter Griscti, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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

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

The following information has been considered in developing this performance report:

* the Assessment Team’s report for the Site Audit conducted 28 March 2022 to 5 April 2022; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 4 May 2022.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Quality Standard is assessed as Non-compliant as 3 of the 6 specific requirements have been assessed as Non-compliant.

The Assessment Team found that most consumers confirmed they felt they are treated with dignity and respect, can maintain their identity and individuality and make informed choices about their care and services. Some examples were provided which the Assessment Team felt undermined the intent of this requirement, however, they found staff spoke about consumers in a way that indicates respect and an understanding of consumer personal circumstances and their life journey. The Assessment Team found care planning in relation to this requirement reflected the diversity of sampled consumers.

The service demonstrated that its care and services are culturally safe, with consumers noting that staff value their culture, values and diversity. Care staff were able to explain how individual consumer cultures shape delivery of care and services, and care planning documents consider specific cultural needs.

The information provided to consumers to enable and support choice was found to be timely, accurate and clear, with the service supporting consumers who have specific needs (such as for vision impairment). Staff were able to describe how they share and communicate information with consumers in ways which suit them.

The service was able to demonstrate that each consumer’s privacy is respected and personal information is kept confidential. Sampled consumers said that staff maintain their privacy and staff described what they do to support confidentiality which was consistent with the organisation’s relevant policies.

However, some consumers and representatives provided feedback that they do not feel that they are treated with dignity and respect and consumers who are cognitively capable have not been consulted about and had the opportunity to give input into their care plan.

The Assessment Team also received feedback from consumers and representatives about the service hindering their ability to maintain relationships of choice because family and loved ones are unable to visit on Sundays.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

The Assessment Team was not fully satisfied the service sufficiently demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Feedback was received from a consumer and representative that felt staff displayed an uncourteous manner. Concerns were raised from sampled consumers and representatives regarding incidents that had occurred in which some staff did not demonstrate their respect for consumers and treated them in an undignified manner.

Some understanding and application of this requirement was demonstrated. For example, the Assessment Team documented interviews with care and lifestyle staff who described how care of consumers has been tailored to them on account of their individuality and life history. Feedback obtained directly from staff during the Site Audit also demonstrated staff are aware of and hold detailed knowledge relating to consumer cultural diversity, including how this influences individual care.

* In their response, the approved provider accepted the Assessment Team’s finding and provided further information, asserting that isolated incidents do not represent usual practice at the service.

However, on balance for the reasons detailed above I find the approved provider is non-compliant with this requirement.

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Non-compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

The Assessment Team were not satisfied the service supports each consumer to exercise choice and independence, particularly in relation to maintaining connections and relationships with others. The Assessment Team also found ‘not all’ consumers are supported to make decisions about their own care and the way it is delivered.

The Assessment Team interviewed representatives who provided feedback stating that are dissatisfied that they are unable to visit on Sundays and that they do not feel their relative is encouraged to get up and do things at the service, resulting in a sedentary lifestyle. Additional feedback provided was that the service was unsupportive in permitting a consumer to attend a case conference to make decisions about their own care and how it is delivered, which had occurred on more than one occasion.

* The Assessment Team noted they had received positive feedback from ‘some’ consumers and representatives regarding how the service supported them to maintain relationships, including in the context of pandemic-related lockdowns, through formats such as video conferencing, telephone calls and window visits.

The Assessment Team’s report notes a care staff had advised there had been a lack of reception/administrative support on Sundays which prevented visitation, which was confirmed by management.

The approved provider’s response indicates acceptance of the Assessment Team’s finding and further information was provided, including clarification that visitation arrangements at the service is not aligned to organisational policy, rather, the protocol had been established based on a local-level risk assessment which considered both Public Health Unit advice and the industry code for visitation. In their response, the approved provider acknowledged communication of the local visitation protocol should have been more sensitive to individual consumer needs.

In considering the evidence provided in the Assessment Team’s report and the provider’s response, I find the approved provider is not compliant with this requirement.

### Requirement 1(3)(d) Non-compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

The Assessment Team were not satisfied the service demonstrated each consumer is supported to take risks to enable them to live the best life they can. The Assessment Team asserted that the service failed to adequately consider and respond to the risk related to consumers who smoke. The Assessment Team found that there had been repeated instances of non-compliance with the service’s smoking rules and the service failed to implement effective monitoring to prevent reoccurrence. Care planning documentation includes that smoking had occurred in rooms and in other inappropriate places with attempts to hide cigarettes and a lighter from staff, which has resulted in the fire alarm being set off.

The Assessment Team identified that the recent smoking hazard assessment and risk acknowledgment form was had not been reviewed or updated since 2018 and the risks were assessed as low. That documentation includes the staff are not to leave the lighter with consumers or give consumers more than one cigarette at a time.

The approved provider has responded in disagreement with the Assessment Team’s findings, with the position that a single incident is not demonstrative overall of the service’s commitment to supporting consumers to take risks. The approved provider has affirmed their view to supporting consumers to take risks aligned with their own (and their representative’s) wishes, including the use of risk acknowledgement documentation and hazard assessments, and feels this does not represent a systemic failure in relation to this requirement.

In forming my view, while I consider that the service has supported some consumers to take risks, there has been a deficit in care on the basis that the potential gravitas of outcome/s of consumers unsupervised smoking and/or use of a lighter could result in significant harm to consumers, or other stakeholders (or a combination of the above).

For the reasons detailed above I find the approved provider is not compliant with this requirement.

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Quality Standard is assessed as Non-compliant as 3 of the 5 specific requirements have been assessed as Non-compliant.

The Assessment Team found that it was not demonstrated that overall assessment and planning consistently consider the risks to each consumer’s health and wellbeing. The Assessment Team found that comprehensive assessments are not being undertaken and management strategies or interventions are not always identified to inform the delivery of safe and effective care. For some sampled consumers post-fall monitoring has not occurred consistent with the service’s falls management and prevention policy.

The Assessment Team found that the service supports consumers to have discussions regarding their advance care planning and end of life wishes (if they wish). Some care plans were found to contain generic statements, whereas others were more individualised.

It was found that assessment and planning occurs in most instances in partnership with consumers and others they wish to have involved in their care. Some representatives confirmed that they are involved in planning, such as through case conferences.

Consumers and representatives confirmed most outcomes of assessment and planning had been communicated to them and their plans were available to them, although in some instances they had additional queries (such as regarding medication) which were not answered in a timely manner.

The Assessment Team found that the service did not demonstrate that care and services are reviewed on a regular basis or when a consumer’s circumstances change or incidents impact on their needs. Care and service records for most sampled consumers show that incidents are occurring, but in some cases an incident report is not being created and incident investigation and management often is not otherwise evident. This relates to behavioural incidents, falls incidents, medication incidents and skin incidents.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team were not satisfied that assessment and planning, including consideration of risks to health and well-being, were in all cases completed and able to inform delivery of safe and effective care.

The Assessment Team’s review of consumer care planning documentation identified gaps in assessment which put consumers at risk though lack of informed and considered care delivery. The Assessment Team also identified a number of consumers who had not received all assessments on day of admission.

In their response, the approved provider acknowledged there have been instances where all elements of assessment had not occurred and therefore did not inform care planning. The approved provider also noted they have undertaken immediate actions to address the issues raised by the Assessment Team in relation to named consumers, and corrective actions are being implemented as part of a systemic response to ensure best practice is observed by staff at all times.

The above examples demonstrate significant gaps in care planning and assessment which has failed to consider and mitigate risks to consumer health and well-being. I am of the view this has placed some consumers at risk of both potential and in some cases actual harm. Accordingly, I find the approved provider is not compliant with this requirement.

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

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

The Assessment Team were not satisfied that the service demonstrated assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning. In particular, the Assessment Team found some care planning documentation to contain generic statements which do not support an individualised approach to care. In addition, the Assessment Team identified inconsistencies across care records in relation to dietary needs, falls risk and advance care/end of life planning documentation.

While generic statements in some consumers’ care planning documentation fails to support staff in providing individualised care to these consumers, an impact to these consumers has not been demonstrated.

The Assessment Team presented information in relation to consumers’ sleep assessment and related charting, noting staff document consumers’ overnight movements on a behaviour chart rather than a sleep assessment (i.e. charting) and the lack of consolidated information and comprehensive review has not supported consumers to achieve optimal sleep. In their response, the approved provider notes that staff document this consumers movements on a behaviour chart, rather than a sleep chart, with the interventions aimed at managing the behaviour which subsequently impacts consumers’ sleep. I am of the view that the approved provider’s justification is sound, and it has ultimately been demonstrated that action is being taken in relation to this consumer’s changed behaviour.

On balance, while it is evident work should be undertaken in addressing inconsistencies between documentation and further individualisation in care planning documentation, I find the approved provider compliant with this requirement.

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

*The organisation demonstrates that assessment and planning:*

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

### Requirement 2(3)(d) Non-compliant

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

The Assessment Team were not satisfied that assessment and planning outcomes are effectively communicated to consumers and documented in a plan that is readily available. Specifically, the Assessment Team raised that care plans are not always reflective of current needs and therefore the outcomes are not effectively communicated or readily available, and the outcomes of care planning are not always effectively communicated to representatives.

I have considered and place weight on feedback from a consumer and their representative that they were unaware of the consumer’s mobility assistance needs, in addition to feedback from a second representative that they were unaware of their relative’s involvement as a victim in an incident. In the latter example, service management noted an alternate representative was notified however the Assessment Team found no record that this had occurred.

The Assessment Team also documented feedback from 2 representatives regarding lack of awareness or understanding relating to medication prescribed for their relatives, and feedback from a third representative in relation to falls risk and prevention strategies. While I consider the medication matter to be primarily within the remit of the consumer’s Medical officer, I am of the view it is reasonable to expect some support from the service in facilitating a discussion to aid in understanding, and similarly to communicate prevention strategies. I note the representative has, however, been notified following falls with explanation of how they occurred.

The approved provider acknowledged the instances where there has been confusion (as noted above) and stated this was promptly rectified once becoming aware.

I acknowledge the approved provider’s response, however at time of the assessment, find that the approved provider is not compliant with this requirement.

### Requirement 2(3)(e) Non-compliant

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

The Assessment Team found the service had failed to review care and services on a regular basis or when there is a change in consumer circumstances or incidents impact their needs. The Assessment Team reviewed care and services records and identified that incidents are occurring, however an incident report is not being created and incident investigation and management often is not otherwise evident. This relates to behavioural incidents, falls incidents, medication incidents and skin incidents.

The Assessment Team identified several consumers where assessments had not been reviewed or updated including a consumer identified as having difficulty sleeping and experiences insomnia, last had their sleep assessment updated in June 2018. Another consumer who suffers ongoing chronic pain, last had their pain assessment updated in August 2021 and a consumer who has experienced pressure injuries since January 2022, had their last skin assessment last updated in June 2021 which identified them at significant risk of pressure injuries. However, noting potential for pain associated with pressure injuries, the service did not reassess or consider potential for pain, with the consumer’s most recent pain assessment and management plan completed in December 2017.

The Assessment Team also noted consumers who experienced unwitnessed falls who did not undergo a reassessment in relation to their falls risk until between one to three months post falls.

The approved provider did not provide a specific response to the Assessment Team’s finding relating to this requirement.

I have considered feedback from service personnel that there is a care plan review schedule in place which notes care plans are updated every three months, however the volume of above examples suggest this is not consistently occurring, nor relevant review processes in response to an incident such as a fall. I am of the view that failure to appropriately reassess consumers both in an ongoing manner and following an incident, and where applicable, plan and implement relevant controls to prevent further reoccurrence of harm, is a significant failing against the intent and purpose of this requirement.

Accordingly, based on the information provided, I find the approved provider is not compliant with this requirement.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as 4 of the 7 specific requirements have been assessed as Non-compliant.

The Assessment team found that some feedback regarding personal and clinical care was positive, and staff were able to describe policies, procedures and training they had received; however, it was not demonstrated that all consumers had received safe and effective clinical care.

The Assessment Team undertook interviews and reviewed documentation which indicates that overall the needs, goals and preferences of consumers nearing the end of their life are recognised and addressed. It was demonstrated the service uses resources such as palliative care specialists to assist consumers to be comfortable as they near end of life.

Communication of consumer needs and preferences appeared to occur in a timely manner through staff handover and electronic records. Similarly, timely and appropriate referrals to individuals, other organisations and providers of other care and services were generally demonstrated. However, gaps were noted in communication of assessment and care planning which means information is not effectively communicated about the condition, needs and preferences of consumers.

The Assessment Team identified that high impact and high prevalence risks associated with the care of each consumer are not being identified, monitored and managed.

An example of appropriate antibiotic prescribing and use was evident in one example. The service overall demonstrated ongoing implementation of strategies to minimise infection related risks at the service. However, gaps were identified in the monitoring and oversight of infection prevention and control practices to ensure consumer safety from COVID-19 infection risks.

**Assessment of Standard 3 Requirements**

### Requirement 3(3)(a) Non-compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team were not satisfied the service could demonstrate, through consumers sampled, that safe and effective personal and clinical care was being provided. Specifically, the Assessment Team raised deficiencies in the monitoring and/or management of changed behaviours and restrictive practices, pain, falls, skin integrity, bowels and medication management.

The Assessment Team reviewed care and service records and identified consumers with ongoing changed behaviours, including physical aggression, which have had frequent and significant impact on them, other consumers and staff. The Assessment Team found interventions and strategies documented are generic in nature, rather than holistic or individualised. The Assessment Team also found pharmacological intervention had not been used as a last resort and progress notes did not indicate appropriate monitoring occurred following use of as required medication.

The approved provider acknowledged the Assessment Team’s findings and provided further information, including that corrective actions have been undertaken in relation to named consumers in the report.

I acknowledge the approved provider’s commitment to address the issues identified in the Assessment Team’s report. However, based on the report and the provider’s response, I find at the time of the Site Audit, it was not demonstrated that each consumer was receiving effective clinical care that was best practice, tailored to their needs or optimising their health and wellbeing, in relation to behaviour management and restrictive practices, falls management, medication management, and management of pain.

Accordingly, I find the approved provider is not compliant with this requirement.

### Requirement 3(3)(b) Non-compliant

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

The Assessment Team were not satisfied that the service demonstrated effective management of high impact or high prevalence risks associated with consumer care, specifically relating to prevention and management of falls.

The Assessment Team reviewed care and service records and identified a consumer who entered the service with recurrent falls with potential for injury. The care plan lacked management strategies or intervention, and the ‘medications that may impact falls/safety’ section was also blank and failed to note blood pressure lowering medication which may cause dizziness. The consumer was found on the floor without injury and the Assessment Team found the service failed to complete post-fall monitoring aligned to the service policy. Documentation showed post-fall vital signs consisted of blood pressure and pulse measurements, taken three times over next two days, but no other observations.

* Another consumer experienced several falls from the bed resulting in bruising and other injuries. The Assessment Team note increasing prevalence of falls, with 5 falls in a month. The Assessment Team noted on 4 of these occasions, observation and monitoring was not undertaken in line with service policy or Medical officer directive. For one fall, a directive to notify the Medical officer if the consumers pulse fell outside range, which was the case twice in one day with no documented follow up.

I am of the view that while the service had been aware of the consumers’ high falls risk and had ample opportunity to formulate and implement falls prevention strategies. It has not been demonstrated if/how this has occurred.

In their response, the approved provider acknowledged gaps in post-falls management and in documentation of the same, in addition to providing further detail relating to the named consumers. I acknowledge the approved provider’s response that immediate actions have been undertaken to address care deficiencies identified by the Assessment Team, in addition broader corrective actions being implemented as part of a systemic response to ensure best practice is observed by all staff.

However, based on the report and the provider’s response, I find at the time of the Site Audit, it was not demonstrated that there is effective management or sufficient response to high impact or high prevalence risk associated with consumer care.

Accordingly, I find the approved provider is not compliant with this requirement.

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

The Assessment Team found, through interviews and review of documentation, that overall the needs, goals and preferences of residents nearing the end of their life are recognised and addressed. However, the service was unable to demonstrate pain monitoring and management for one consumer, in addition to gaps in palliative care planning.

* I have considered that there is evidence that for consumers sampled, staff were responsive to consumers’ end of life care needs, including administering medications for pain and facilitating visits from palliative specialists, however, there is opportunity for improvement including faster development of specialist care plans to guide staff on how to best support consumers at end of life. As noted under other requirements, pain management and care planning and assessment are demonstrated areas in which attention is needed.
* I have also considered staff feedback and the Assessment Team’s observations during the Site Audit, which describe the way comfort care is delivered to consumers who are approaching end of life.
* The approved provider’s response affirms their commitment to supporting consumers and representatives in relation end of life care, including having high engagement with external specialists and providing high levels of psychological, emotional and spiritual support to both consumers and representatives.
* Accordingly, while improvement opportunities should remain an ongoing focus, I find the approved provider compliant with this requirement.

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

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

The Assessment Team found the service did not demonstrate deterioration or change in consumer condition is recognised and responded to in a timely manner. The Assessment Team provided the following information and evidence relevant to my finding:

The Assessment Team interviewed consumers and representatives and reviewed care planning documentation. The Assessment Team identified that skin integrity had not been managed for consumers and despite regular interaction staff failed to identify a deterioration in a consumer’s condition before it was identified by a representative.

Feedback provided by a representative was that on a few occasions staff had failed to pick up when a consumer’s condition has changed which had previously indicated they have a urinary tract infection. The representative noted that they had on one occasion picked up that the consumer was ‘completely out of it’ when speaking by phone, and upon raising it with staff, the consumer was found to have a urinary tract infection.

* I have considered the approved provider’s response which acknowledges gaps in documentation and notes this matter has been discussed with staff as a matter of priority.
* Based on the above examples, I do not consider the service has demonstrated timely identification or an adequate response to changes in consumer condition.
* Accordingly, I find the approved provider is not compliant with this requirement.

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

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

The Assessment Team found the service was unable to demonstrate information about the consumer’s condition needs and preferences is documented and communication within the organisation, and with others where responsibility for care is shared.

The Assessment Team reviewed care planning documentation and identified for a consumer returning from hospital, a hospital discharge report was not sought in a timely manner to understand their condition and needs upon return to the service.

* Additionally, for one consumer, care staff appeared unaware of recent changes made to their mobility/transfer requirements by a Physiotherapist.

The approved provider responded to the Assessment Team’s findings and provided further information in relation to the above examples. It has been previously identified, and acknowledged by the approved provider, there are inconsistencies and deficits in record keeping. It was noted during the Site Audit that review of the discharge summary and anything to be followed up is picked up on return from hospital, however it did not happen in the abovementioned example.

I acknowledge the providers response however find that the approved provider is not compliant with this requirement.

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

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

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team have identified gaps in the monitoring and oversight of infection prevention and control practices to ensure consumer safety against COVID-19 infection risk. However, they noted appropriate antibiotic prescribing and use for one consumer, and overall the service demonstrated implementation of strategies to minimise infection related risks.

The gaps raised by the Assessment Team include, for example, information from one staff showing a deficiency in knowledge of service processes, a staff member failing to take a resident’s temperature daily as indicated in their infection form, inconsistency in Rapid Antigen Test instructions and observation of a staff member wearing their mask incorrectly and a number of additional observations of minor infection prevention and control breaches.

The Approved Provider’s response to this Requirement details that they disagree with the Assessment Team’s finding on the basis that ample detail demonstrates how the service meets this Requirement.

In considering the evidence presented by the Assessment Team, I am of the view that while there are minor improvements which the service has acknowledged they have already begun to focus on, on balance the service sufficiently demonstrates adequate understanding and application of this Requirement.

On balance of the evidence provided, I find the approved provider compliant with this requirement.

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as Non-Compliant as 2 of the 7 specific requirements have been assessed as Non-compliant.

The Assessment Team found many sampled consumers felt they get the services and supports for daily living which are important for their health and well-being and enable them to do the things they want to do. For example, positive feedback was received regarding the household model of dementia care and individualised recreational plans for consumers living in the dementia areas, however consumers in other areas were not as positive about the support they receive to do things. Care staff were able to explain what is important to consumers and what they like to do and this was largely consistent with their care plans.

Staff were able to identify how they know when consumers are feeling down and could describe support strategies aligned to individual needs documented in care plans. The service demonstrated how it supported consumer spiritual well-being needs, such as pastoral care, including during pandemic-related isolation periods. However, there were a significant number of consumers and representatives that expressed concerns about family members and loved ones being unable to visit on Sundays, which for some was the only day they could get to the service to see their loved one.

The service demonstrated that timely and appropriate referrals to individuals, other organisations and providers of other care and services are being made, within the context of COVID-19 lockdowns and restrictions.

The service demonstrated overall that meals are suitable, however, some feedback indicated there could be increased variety and improved quality in some meals. It was demonstrated there are forums and mechanisms to influence meals, and based on feedback, this should remain an area of focus for the service.

Equipment provided by the service was found to be overall safe and well maintained, with maintenance records demonstrating there are proactive and reactive maintenance operations occurring. However, some feedback was received regarding issues with mechanical lifters, prompting a recent purchase of a new one.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

The Assessment Team were not satisfied on the whole that the service demonstrated each consumer gets safe and effective services and supports for daily living which meet their needs, goals and preferences. However, they noted a difference between the service’s secure area for consumers living with dementia (where feedback from representatives suggested needs were being met) and other areas of the service, where feedback from consumers and representatives was less positive in relation to consumer needs and preferences being met.

The Assessment Team documented examples of individualised care services and supports, including positive feedback from a representative which discussed how staff bringing an animal on site improves quality of life. However, one representative noted they often find their relative with no stimulation. A second representative raised concern regarding lost clothing items which was raised with a staff member.

Care planning documents sampled demonstrated the service has considered individual needs and staff feedback included explanation of how they tailor activities to meet the needs of consumers of varying level of functional ability.

The approved provider, in their response, disagrees with the Assessment Team’s overall view, and notes the primary negative issue raised (relating to misplaced laundry) has been promptly followed up with the complainant.

In considering the evidence provided in the Assessment Team’s report and the provider’s response, I have placed weight on the majority of evidence provided being positive, in addition to the large body of knowledge demonstrated by staff in relation to tailoring services and supports for individual consumers and for those with varying levels of functional and cognitive ability. While I note the complaint in relation to missing laundry, I consider it more relevant to consider in relation to Standard 6.

For these reasons, I find that the approved provider is compliant with this requirement.

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The Assessment Team were not satisfied the service demonstrated each consumer receives services and supports for daily living which promote emotional, spiritual and psychological wellbeing. The Assessment Team note that on the whole, feedback from consumers and representatives was positive in relation to the service’s offering. However, they note feedback had been provided by a representative about an incident where a consumer was subject to verbal abuse by a staff member, and feedback from a consumer in relation to limited support from the service being given to those who are nearing end of life.

The approved provider disagreed with the Assessment Team’s findings and provided reasoning in their response, including the allegation of lack of care at end of life not being supported by the Assessment Team’s observations during the Site Audit and the volume of positive findings documented in care planning documentation in fact supporting a compliant finding on this requirement.

I consider both consumer feedback and staff feedback noted under this requirement very relevant to my finding of compliance, including 2 comments regarding uplift in the wellbeing of 2 different consumers following loss as a result of the service and staff support. I also note the service found contemporary solutions during the ongoing pandemic to continue delivering activities which support spiritual wellbeing, including streaming church services and church karaoke directly to individual consumer rooms.

For the reasons detailed above I find that the approved provider is compliant with this requirement.

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

The Assessment Team were not satisfied the service demonstrated each consumer gets safe and effective services and supports for daily living, which assist them to participate in their community within and outside the service environment, have personal and social relationships, and do things of interest to them. It is primarily the latter of these areas to which the Assessment Team received negative feedback from consumers and a representative.

The Assessment Team received positive consumer feedback regarding the household model of dementia care and individualised recreational plans for consumers living in the Wattle and Willow dementia areas, however received feedback from some consumers and representatives in other areas of the service who advised that there is insufficient recreational stimulation.

Several examples have been provided which overall demonstrate how the service supports consumers to maintain social and personal relationships, including feedback that they kept in touch through digital means throughout the pandemic, and the service had still accommodated visits and outing though noting there were increased requirements such as (in some cases) isolation upon return.

The Assessment Team reviewed care planning documentation and noted mostly individualised information with regard to consumer interests and preferences, however, noted one consumer has generic and/or limited information in their care plan under the personal, relationship and community needs and activities section, to which the Approved Provider has confirmed they have rectified upon becoming alerted.

* On balance of evidence presented, I find that the approved provider is compliant with this requirement.

### Requirement 4(3)(d) Compliant

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

The Assessment Team were not satisfied the service demonstrated information about the consumer’s condition, needs and preferences is communicated internally and with others where responsibility for care is shared.

While some sampled consumers felt that their condition, needs and preferences are effectively communicated within and between organisations, other consumers and representatives raised concerns about the consumer’s needs not being met because of ineffective inter- and intra-service communication and lacking documentation.

Representatives provided feedback that some meals are unpalatable or unsuitable for consumers with gluten intolerance and what is not eaten is disposed of and not taken back to the kitchen, therefore the cooks do not know what the consumer likes and dislikes. Although it has been brought up at resident and representative meetings, the information is not being shared.

While there are opportunities for improvement in documentation, addressed under Standard 2, I have placed weight on staff feedback which demonstrates there is a system for information sharing and updating others with changes to consumer needs or preferences, including relating to food, care, and lifestyle needs. Information has also been included which shows how communication with allied health personnel (the example of a physiotherapist is provided) occurs.

In their response, the approved provider provided reasons why they disagree with the Assessment Team’s finding, however, do acknowledge some areas for continuous improvement.

On balance of the evidence presented, I have found the approved provider compliant with this requirement.

### Requirement 4(3)(e) Compliant

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

### Requirement 4(3)(f) Non-compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The Assessment Team were not satisfied the service overall demonstrated meals were satisfactory to consumer needs and preferences, however, noted this was primarily in relation to quality and variety with consumers feeling the amount of food provided is sufficient. The Assessment Team noted the service’s chef acknowledged feedback trends in past food surveys had not been analysed and did not influence menu planning.

The approved provider acknowledged coordination of feedback mechanisms in relation to food would benefit from attention and stated the service has already begun to act on the feedback contained within the Site Audit report which has been positively received by consumers and representatives.

The Assessment Team interviewed consumers and representatives and of the sampled consumers, only one consumer said the food is ‘fine’ with other stating they get enough to eat, and drink and the food is ‘alright’. Other consumers have provided examples of where food is undercooked, tasteless, bland or unappetising. Consumers and representatives confirmed that they have given feedback through the resident and representatives meeting and to staff and feel that they have not been heard and there has been no improvement, one representative said when things are raised they change the topic. One consumer presented photos to the Assessment Team of meals from the last month date stamped and noted to be unsatisfactory. A consumer also advised that the service had previously provided fresh fruit and biscuits, however this is no longer available and the representative brings this in.

The Assessment Team observed the kitchen to appear clean and tidy and staff appeared to be observing food safety and general health and safety principles. Similarly, the most recent local health authority audit was viewed which has a small number of areas to be rectified which were confirmed as either in progress or completed by the head chef. The team also noted dietary information is met for consumers.

I acknowledge the providers feedback, however find that the service has failed to listen to consumers in relation to the meal offerings and looking for continuous improvement opportunities. This includes seeking, analysing, and incorporating feedback sought from consumers across the service.

I find that the approved provider is not compliant with this requirement.

### Requirement 4(3)(g) Non-compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

The Assessment Team were not satisfied that the service-provided equipment was safe, nor well-maintained for consumer use, citing an incident approximately 6 weeks prior to the Site Audit where a lifter stopped working while being used. Care staff noted this caused distress for the consumer who was being transferred at the time. It is noted that a new lifter was purchased and delivered to the service following this incident.

The Assessment Team received feedback on the day of the Site Audit, that every lifter needed new batteries, but the backup batteries were flat. Staff advised that they have reported this to maintenance, however the issue keeps occurring.

The Assessment Team also identified that a long delay for a consumer with significant risk of pressure injuries to have an air mattress despite the representative requesting it on 2 occasions.

The approved provider did not provide a specific response to this requirement.

The Assessment Team viewed logs showing there is regular maintenance of furniture and equipment, however, given feedback from staff regarding issues specifically relating to lifters, there appears to be ongoing problems with batteries or lifters.

I find that the approved provider is not compliant with this requirement.

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as 3 of the 3 specific requirements have been assessed as Compliant.

Feedback confirmed the service is clean and well maintained and consumers feel at home living at the service. Consumers said they are able to decorate their rooms family and visitors are made to feel welcome. Consumers confirmed they have access to indoor and outdoor living areas.

Observations of the environment show the service is appropriately furnished and decorated and is clean and well maintained. The Assessment Team observed many shared areas for consumers to interact across the service, including the cafe, verandas, games room, small cosy alcoves with a few seats and side tables, a reading room with a filled book case, craft room, covered outdoor patios, and lounge areas. Navigational signage was clear and most rooms were personalised.

Staff interviewed, and maintenance and cleaning records confirmed there are processes in place to ensure proactive and reactive cleaning and maintenance of the service environment and equipment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

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

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Non-compliant as 3 of the 4 specific requirements have been assessed as Non-compliant.

The Assessment Team found that some consumers and representatives felt they could raise concerns and provide feedback, but others did not feel supported to do this. While there is a policy and structure/feedback mechanisms, it does not appear to be fully effective.

The Assessment Team interviewed consumers and representatives and found that some, but not all consumers and representatives felt their feedback was heard or actioned, and it was not evident that outcomes are consistently documented or used to pursue continuous improvement opportunities. It was not evident that open disclosure principles are consistently used – not only as part of a complaint resolution process, but rather in situations where a less than ideal outcome has occurred.

However, it was demonstrated that advocacy services and other methods for raising and resolving complaints have been promoted to consumers and relatives. consumers and representatives interviewed are aware of advocacy services and the external aged care complaints mechanism for raising and resolving complaints.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Non-compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

The Assessment Team were not satisfied the service adequately supports consumers, their representatives, friends, carers and others to provide feedback and make complaints. Whilst some consumers and representatives reported they would feel comfortable giving feedback or making a complaint, others felt the complaints and feedback process was unsupportive and did not feel ‘listened to’ because of service inaction following them raising concerns.

On review of documentation the Assessment Team observed that the service has a feedback and complaints policy, in addition to maintaining complaints records, although actions taken by the service have not been consistently documented.

* The service undertakes an annual food survey, although it is noted there was only one response for the 2022 survey and it has not been used to inform meal services.
* Feedback mechanisms are promoted through various means, including admission documentation, the Resident handbook and notices throughout the service environment.
* On balance, while it is evident the service provides avenues for consumers and other stakeholders to provide feedback and raise complaints, I have placed weight on consumer and representative feedback that they feel unsupported or uncomfortable to do so for concern of reprisal or victimisation.

The approved provider responded to the Assessment Team’s findings, noting a Clinical Governance and Quality expert has been engaged to initiate improvements to the feedback and complaints process as a top priority.

* I also acknowledge the service’s proactive action by engaging a consultant to seek improvement in this area of care and service delivery. However, for the reasons detailed above I find the approved provider is non-compliant with this requirement.

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Non-compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team were not satisfied the service demonstrated appropriate action has been taken in response to complaints, including use of an open disclosure process when things go wrong. While one consumer and 4 representatives said their concerns were addressed when they raised them, 6 representatives were dissatisfied with the service’s response to their complaint(s). Two representatives stated they needed to raise concerns multiple times and 3 representatives felt their concerns had not been satisfactorily addressed.

* The Assessment Team identified that food complaints do not appear to have been used to improve meal services. While the Assessment Team notes that complaints records show some complaints have been responded to and open disclosure practiced, there is no resolution noted for others. The Assessment Team received multiple complaints regarding restricted visitation, however, this does not appear to have been actioned by the service.
* The service has a feedback and complaint policy which references guidelines to open disclosure, however, I note no examples of open disclosure have been provided where the service self-identifies an issue or deficit in care or service delivery which can demonstrate deep understanding of this concept.

The approved provider responded to the findings under this requirement noting the actions outlined including updated tools and procedures, to ensure that gaps are rectified.

* On balance, while some examples have been provided by consumers where they felt appropriate action was taken by the service, I am of the view further action is required to demonstrate compliance with this requirement, including maintaining consistent records to demonstrate stakeholder concerns are addressed, and practise of open disclosure when issues are self-identified – not purely as a component/principle of complaint resolution. Accordingly, I find the approved provider non-compliant with this requirement.

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team were not satisfied the service demonstrated use of feedback and complaints to improve the quality of care and services, noting the service does not have a consolidated record of all complaints to assist in identifying complaint trends, and the service’s Plan for continuous improvement (PCI) lacks information to demonstrate if/how complaints are used to inform improvement opportunities.

In forming a view of compliance against this requirement, I have placed weight on feedback presented under multiple requirements, including relating to meals, where it has been acknowledged from service personnel that feedback provided had not influenced the service menu. I have also considered the Assessment Team’s finding about recording complaints and reason that failing to record and consolidate complaints limits ability to properly identify, analyse and act on trends.

The approved provider responded to the findings under this requirement noting the actions including updated tools and procedures, which would ensure that gaps are rectified.

The Assessment Team noted 3 of the 2022 entries in the service’s PCI were generated from complaints, however, were advised 2 of these were yet to be actioned at the time of the Site Audit. No entries were noted for the second half of 2021, to which a senior service staff member advised was due to competing demands at the time which did not allow for this.

Accordingly, I find the approved provider is not compliant with this requirement.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as 3 of the 5 specific requirements have been assessed as Non-compliant.

The Assessment Team found that the service was unable to demonstrate allocation of staff consistently meets the needs of consumers, including indirect needs relating to care as noted under other Standards (such as timely and consistent completion of assessment and planning). However, some consumers and representatives were satisfied with the number and mix of staff.

The Assessment Team interviewed consumers and representatives and found some did not have concerns about the staffing mix or level, however many had concerns about the staffing level and some spoke of this impacting on them or their relative. Staff interviewed had concerns about working short staffed. Review of rostering shows most days multiple care staff shifts are unfilled or are partially filled. Review of call bell response times shows while most calls are answered within benchmark, however some are not and the latter aligns with feedback from consumers about waiting too long for the staff to respond. Management explained the workforce and staffing challenges and what has been and is being done to address these. At this time the workforce as deployed does not enable the delivery and management of safe and quality care and services.

Most feedback demonstrated that staff are kind, caring and respectful, and generally knowledgeable and skilled enough to meet their/their relative’s care needs. However, some provided information or raised a concern about staff not treating consumers with dignity and not showing them respect. Specific examples were given of how this has negatively impacted the consumers. Most consumers and representatives felt staff had sufficient training in relevant areas. However, records suggested there was outstanding training to be completed in some areas and workforce understanding of some areas, including serious incident reporting, requires attention.

The organisation has relevant human resource management documentation which provides guidance for management and staff about staff performance development and management. There is a system and processes for staff performance assessment, and records reviewed show these are being implemented at the service.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team were not satisfied the workforce is planned to enable, nor the number of workforce deployed sufficient to enable, the delivery and management of safe and quality care and services.

Of the 12 consumers interviewed during the Site Audit, comments from 4 of these identified that there were insufficient numbers of staff with the impact that staff were unable to assist in a timely manner when consumers use their call bell. Comments from 4 representatives also included concern regarding timeliness of assistance. One of these, who has a relative living with dementia, said this has impacted safe medication management, falls management and timely identification of clinical deterioration. A second representative also linked staff failing to pick up on changes in their relative’s condition (subsequently linked to a urinary tract infection) due to understaffing. It is important to note, there was also feedback that suggested the staff do attend to consumer needs promptly where they can.

Four responses to a consumer and relative satisfaction survey conducted January to May 2021 also noted concern about call bell response, with one respondent noting their parent spent ‘quite a lot of time on the floor’ (presumably following a fall) and one consumer added that sometimes he has to wait a long time to go the bathroom.

In their response, the approved provider disagreed with the Assessment Team’s finding and provided reasoning. They note they are subject to the critical worker shortage within the sector that all health and aged care providers currently face, however had been proactive in engaging strategies to mitigate this. These strategies include undertaking an in-depth review and redesign of the roster, a recruitment strategy driven by the corporate human resources department, and engagement with local training providers to source staff. The response also notes the service delivers a higher than benchmark direct care minutes per consumer. While this is a positive metric, it does not strictly correlate with compliance with this requirement which is more closely focused on whether the staffing number and mix is sufficient and appropriate to deliver safe and quality care for consumers.

Accordingly, I find that the approved provider is not compliant with this requirement.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

The Assessment Team interviewed consumers and representatives who confirmed the staff are kind, caring and respectful, however some provided information or raised a concern about staff not treating consumers with dignity and not showing them respect. Specific examples were given of how this has negatively impacted the consumers. Other information gathered, including from interviews with staff and observations of staff practice, showed staff were kind, caring and respectful to consumers.

The approved provider provided a response to this requirement and refutes the Assessment Team’s finding, noting a large body of positive feedback regarding staff conduct, documented during the Site Audit, demonstrates how the service meets this requirement.

The feedback in relation to negative workforce interactions, while important to consider nonetheless, is a fraction of the total feedback received which casts an overwhelmingly positive light on the quality of staff interaction with consumers. Feedback includes that staff are helpful, professional and sympathetic to consumer needs, and demonstrates staff are knowledgeable about consumer needs and delivery of individualised care.

I have considered that the service has organisational documents (including a code of conduct) to guide staff practice, could provide multiple pieces of written positive feedback from representatives about staff conduct, and the Assessment Team observed kind, caring and respectful interactions during the Site Audit.

Accordingly, I find the approved provider is compliant with this requirement.

### Requirement 7(3)(c) Non-compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team were not satisfied the service could demonstrate a competent workforce with members who have the qualifications and knowledge to effectively perform their roles. The key concerns raised related to the service not demonstrating oversight of medication competency and management lacking knowledge in areas relevant to their role and responsibilities, in particular relating to regulatory changes in the past 12 months. This has affected service performance against the Quality Standards in a range of areas.

The Assessment Team identified breaches of safe medication administration in the past 6 months. It was noted that the medication competency assessment tracker showed most care staff had not completed their medication competencies in the last 12 months.

The Assessment Team identified that management did not demonstrate knowledge in some areas relating to restrictive practice and did not demonstrate an understanding of the Serious Incident Response Scheme (SIRS). The Assessment Team’s findings are that many serious reportable incidents have not been reported, escalated internally and considered as possible SIRS incidents, with under-reporting to the Commission evident.

The approved provider responded to the Assessment Team’s findings and acknowledged some knowledge gaps in relation to recent regulatory changes.

I agree with the Assessment Team’s finding that certain knowledge areas, including an understanding of serious incident reporting, restrictive practice (including chemical) and behaviour support planning should be well-understood by senior or management personnel and medication competencies should be completed by all staff involved with administration of medication.

Accordingly, I find the approved provider is not compliant with this requirement.

### Requirement 7(3)(d) Non-compliant

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

The Assessment Team were not satisfied the service demonstrated the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. However, it was noted most consumers and representatives felt staff had sufficient training. The Assessment Team’s view is that while some staff have attended training in specific areas, including skin care and wound management, and restrictive practices, it has been insufficient or ineffective as demonstrated by findings under Standard 3 Personal and clinical care. Further, the Assessment Team identified some deficiency in staff and management knowledge in relation to serious incident reporting and pain management, where limited or no training has been undertaken.

The approved provider accepted the Assessment Team findings and note that corrective actions are being undertaken as a high priority.

I find the approved provider is not compliant with this requirement.

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

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

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as 4 of the 5 specific requirements have been assessed as Non-compliant.

The Assessment Team found the organisation has a consumer engagement framework, however, felt it did not reflect best practice and is not tailored to the organisation. Consumers and representatives were aware of some of the ways they can have input, however some who had given feedback or made a complaint and did not think this had made a difference. Other ways the organisation proposed to evidence consumer engagement were explored by the Assessment Team and most do not show recent engagement. The CEO spoke of ways consumers are being engaged, however most examples relate to other residential aged care services. A new partnering in care program is being implemented, however overall at the time of the site audit and in recent months it was not demonstrated that consumers have been engaged in the development, delivery and evaluation of care and services.

There have been deficiencies demonstrated in organisation-wide governance systems in relation to continuous improvement, regulatory compliance, workforce governance and information management. Further, while there are some examples of how the service monitors and manages risk, significant work remains to demonstrate integrated and effective risk management systems and corresponding practices.

## Assessment of Standard 8 Requirements

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

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

The Assessment Team were not satisfied that the service sufficiently supports consumers to be engaged in the development, delivery and evaluation of care and services.

The Assessment Team found that the organisation has a consumer engagement policy/procedure, however, felt that the policy/procedure does not include sufficient referencing to best practice guidelines for consumer engagement in aged care; or about any co-design practices for consumer engagement at organisational level.

The Assessment Team interviewed consumers and representatives who spoke of attending resident/relative meetings. Some said they find the meetings useful, others said they do not. The consumers and representatives also said they are invited to give feedback via surveys and they were aware of the feedback and complaint mechanisms.

I also note, throughout other Standards, mixed examples where consumers and/or representatives have been engaged in development and delivery of care and services, however few, if any, examples of engagement in evaluation have been demonstrated.

* In their response, the approved provider provided further commentary regarding consumer engagement in care and services. The approved provider, in their response, detailed 3 examples of where feedback has directly led to successful initiatives at the service, including relating to entertainment, mail delivery and involvement in meal preparation.

With the caveat that continuous improvement, in effect, continuing and persistent efforts to involve consumers in all areas of care design, delivery and evaluation should be a matter of focus for the Approved Provider, I find the approved provider is compliant with this requirement.

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

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

The Assessment Team were not satisfied there was adequate demonstration of how the organisation’s governing body promotes a culture of safe, inclusive and quality care and services, and demonstrates accountability for their delivery.

* The Assessment Team were provided with evidence of governing body meetings show that information is presented and discussed at meetings about organisational improvement projects and programs, such as introducing a commercial insights and benchmarking system (Moving on Audits) and a corporate COVID-19 management plan. Other than a privacy breach for a consumer at another of the organisation’s residential aged care services, it was not demonstrated that any clinical quality and safety data or information about consumers has been presented and discussed.

The Assessment Team identified that there is monthly reporting to the Chief Executive Officer by senior clinical/management personnel shows they are limited in scope. They include questions/answers from a previous version of the Commission's risk based questions, a prompt for information about the percentage of care plans up-to-date; and a free text field, however despite prompts, does not include the number of consumers being chemically restrained.

The governing body is not receiving and has not been receiving relevant information in relation to safe, inclusive and quality care and services to inform business planning, risk management and for effective oversight to know about service performance against the Quality Standards. It has not been demonstrated the governing body is accountable for the delivery of safe, inclusive and quality care and services.

In their response, the approved provider disagrees with some of the Assessment Team’s report and provides further insight regarding the organisations’ governing body involvement and accountability to care delivery.

I acknowledge the work being undertaken by the approved provider in refining their reporting mechanisms, however do not find that the approved provider is compliant with this requirement at the time of assessment.

I find that the approved provider is not compliant with this requirement.

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

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

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

The Assessment Team found the service was unable to demonstrate effective organisation wide governance systems in all areas noted under this requirement with exception to financial governance. In their Site Audit report, the Assessment Team note deficiencies in relation to information management, regulatory compliance and workforce governance, and opportunities for improvement in relation to information management and feedback and complaints.

The Assessment Team found in relation to information management: the volume of evidence, strongly indicates there are insufficient governance mechanisms to ensure information relating to consumer condition and assessments, needs and preferences, feedback and complaints and clinical monitoring is accurately and sufficiently captured, reviewed and evaluated with a view to improvement of both individual consumer and that of the consumer cohort.

The Assessment Team found in relation to continuous improvement while the service’s internal quality assurance processes are being implemented, benchmarked clinical indicators are not being measured in some areas, and are inaccurate due to underreporting. The Assessment Team also note there are no entries in the service’s Plan for continuous improvement (PCI) in the second half of 2021 showing links between findings and improvements.

The Assessment Team found in relation to workforce governance that the governing body was made aware of staffing challenges, including in relation to recruitment difficulty, staff overtime and increased management workload. No evidence has been provided, with exception to ongoing recruitment, as to strategies which demonstrate there is a planned and monitored system to ensure the workforce is capable to deliver safe and quality care and services.

The Assessment Team found in relation to regulatory compliance, that the service does not have a sound or thorough understanding of legislative requirements relating to psychotropic medication use, including documentation and ongoing monitoring requirements. Similarly, there are deficiencies relating to knowledge of the Serious Incident Reporting Scheme (SIRS) and associated reporting requirements.

The Assessment Team found in relation to feedback and complaints, that there is a reporting mechanism which assists with oversight and note feedback that a Director and the Chief Executive were aware of both external and repeat complainants. However, it was not demonstrated there has been monitoring in relation to complaint trends, and the findings in relation to Standard 6, particularly relating to the use of feedback and complaints to inform improvements to care and services suggest there is inadequate oversight to ensure this is an area of ongoing focus for the service.

I acknowledge the approved provider’s response that work is being urgently undertaken at an organisation-wide level, including engagement of a clinical governance expert to assist in development and implementation of a best practice system. However, I do not consider that the service has demonstrated adequately effective governance systems in the aforementioned areas.

I find that the approved provider is not compliant with this requirement.

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

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

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

The Assessment Team were not satisfied that there were sufficient risk management systems and practices, including but not limited to managing high impact or high prevalence risks, identifying to abuse and neglect, supporting consumer quality of life and managing and preventing incidents, including effective use of an incident management system.

I have considered the Assessment Team’s finding that the service does have a documented risk management and governance framework, however, on review information presented under other Standards I am of the view it has been ineffective in managing high impact or high prevalence risk, specifically in relation to both falls and pain. No evidence has been demonstrated that there is systematic review of incidents, trending, evaluation, or use of findings to develop and deploy effective mitigation strategies for consumers who fall, exhibit changed behaviours or have known pain, based on repeat occurrences or issues in these areas for multiple consumers. Similarly, there are multiple inferences through the Site Audit report that incidents, including falls, have failed to be recorded as an incident, preventing the service from achieving effective monitoring.

The Assessment Team notes no policy or procedure was provided which outlines how the organisation manages serious incidents or the service’s approach to preventing abuse and neglect. I have also considered the possibility that there are deficiencies in training or a lack of education provided to staff, resulting in potential underreporting of serious incidents.

The Assessment Team found that while the organisation has incident management policy/procedure documentation, it has not been followed by staff.

I have reflected on the approved provider’s response, which both acknowledges the Assessment Team’s findings and notes implementation of corrective actions are underway, and also note findings under Standard 1, being that the service has demonstrated some understanding of supporting consumer quality of life through supporting dignity of risk.

On balance, I do not consider that the service has demonstrated effective risk management systems. Accordingly, I find the approved provider is not compliant with this requirement.

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

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

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

The Assessment Team found that while the organisation has a documented clinical governance framework, the service has been unsuccessful in implementing its components. In their response, the approved provider acknowledges the Assessment Team’s findings and notes implementation of corrective actions are underway.

In relation to effective antimicrobial stewardship I have considered the evidence presented under this requirement, in addition to other Standards. The Assessment Team note there is an antimicrobial stewardship policy/procedure, however it relates predominately to antibiotic prescribing rather than an overarching or multifaceted antimicrobial stewardship program. The Assessment Team assert that documentation does not include guidance on performance monitoring of antimicrobial stewardship, and service personnel confirmed prescribing is not measured as a clinical indicator.

In relation to restrictive practices, the Assessment Team found that while there is organisational policy and procedure, there is a lack of understanding and application through demonstration of improper use of psychotropic medication for multiple consumers. I also note, evident under other Standards, that there is a lack of monitoring and review. While feedback from senior/clinical personnel showed there is support for reduction of chemical restrictive practice, it did not show there is a structured or monitored system for ensuring this consistently occurs.

In relation to use of open disclosure, the service was found to have relevant policy and procedure which the Assessment Team felt was consistent with best practice. However, the feedback and complaints policy documentation did not include information about open disclosure. The Assessment Team note there is a lack of consistent practice of open disclosure, based on feedback from consumers, representatives and review of incident reports.

I have considered the Assessment Team’s findings noted under this specific requirement, and further examples noted elsewhere in the Site Audit report. In particular, the evidence relating to restrictive practices noted under Standard 3 suggests a lack of staff knowledge and understanding, a lack of structured monitoring during use of psychotropic medication, insufficient documentation practices and lack of a coordinated approach to reduce use of restraint where possible.

Accordingly, I find the approved provider is not compliant with this requirement.

# 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 1(3)(a) Non-compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

* The approved provider must demonstrate:
* Staff conduct is consistently of a manner which makes consumers feel they are treated with dignity and respect.

### Requirement 1(3)(c) Non-compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*
* The approved provider must demonstrate:
* Consumers are consistently support to make and maintain connections with others, including in relation to facilitating visitation (with respect to any relevant Public Health Unit advice).
* Consumers are given full opportunity, through both inviting and supporting them, to participate in decision making related to their care and services.

### Requirement 1(3)(d) Non-compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

* The approved provider must demonstrate:
* Where risks associated with consumer activities are identified or known, they are regularly and comprehensively reviewed to ensure mitigation strategies are accurate, timely and documented.

### Requirement 2(3)(a) Non-compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

* The approved provider must demonstrate:
* Assessments and care plans include risks associated with the consumers care and related strategies.
* Assessment and care plans are reviewed and updated when new risks are identified.
* Incident investigation is conducted and documented to inform the review of the care plan and to implement effective strategies for staff to prevent the incident reoccurrence.
* Documentation is comprehensive and accurately reflects individual needs.

### Requirement 2(3)(d) Non-compliant

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

* The approved provider must demonstrate:
* Consumers are provided opportunity to ask questions and be informed of the outcomes of care planning, including support to understand aspects of their care delivery such as medication.

### Requirement 2(3)(e) Non-compliant

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

* The approved provider must demonstrate:
* Documented needs are regularly reassessed, including when incidents or circumstances may impact or change those needs.
* Consumers’ care and services are regularly reviewed for effectiveness when consumer incidents occur, including falls, behavioural and skin injury incidents.
* Investigation to understand factors contributing to consumer incidents to inform care planning and prevent future incidents are conducted.
* Recording of incidents should include complete description and contributing factors of the incident, actions taken by staff and strategies to prevent future incidents.

### Requirement 3(3)(a) Non-compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*
* The approved provider must demonstrate:
* Consumers personal and clinical care is tailored to their needs and optimises their health and well-being, specifically relating to behaviour management, management of restrictive practices, pain, and falls.
* Medical officer directives are followed and documented.
* Pharmacological interventions in response to behaviours of concern are used as a last resort with other strategies trialled prior and effectiveness consistently measured.
* Appropriate monitoring is undertaken following incidents and interventions applied by the service.

### Requirement 3(3)(b) Non-compliant

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

* The approved provider must demonstrate:
* Assessments and monitoring charts are fully completed following any incidents.
* Medical officer directive is followed for consumers and recorded consistently, specifically in relation to post falls management.

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

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

* The approved provider must demonstrate:
* Clinical monitoring accurately and promptly identifies change in condition or deterioration, and actions are taken in response.

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

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

* The approved provider must demonstrate:
* The service documents, and staff are made aware of, changes in a consumer’s condition and/or changed care needs, including following hospital discharge.

### Requirement 4(3)(f) Non-compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

* The approved provider must demonstrate:
* Feedback regarding meal quality and variety is sought, documented and used to seek continuous improvement.

### Requirement 4(3)(g) Non-compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

* The approved provider must demonstrate:
* Application/installation of relevant equipment is provided promptly when it is determined to be required.
* Equipment required for consumer care, including lifters, are monitored in an ongoing manner for functionality.

### Requirement 6(3)(a) Non-compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

* The approved provider must demonstrate:
* Feedback systems are robust, responsive and supportive of consumers and others being able to share their views without feeling victimised or for concern of retribution.

### Requirement 6(3)(c) Non-compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

* The approved provider must demonstrate:
* Appropriate action is consistently taken in response to feedback and complaints, feedback is consistently documented, and open disclosure is used both during complaint resolution and in scenarios where the service self-identifies something could have been done better.

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and service*

* The approved provider must demonstrate:
* Feedback and complaints are regularly and thoroughly reviewed and used to pursue continuous improvement of care and service delivery, including in relation to meal services.

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

* The approved provider must demonstrate:
* A robust system for ensuring staffing numbers are sufficient, including that rostered shifts are filled, to enable to delivery of safe and quality care.
* Call bells and sensor alerts are responded to by the staff within a reasonable time.

### Requirement 7(3)(c) Non-compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

* The approved provider must demonstrate:
* Staff, including management, are fully competent in areas relevant to their roles, including clinical matters such as medication administration, serious incident reporting, restrictive practices and behaviour management.

### Requirement 7(3)(d) Non-compliant

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

* The approved provider must demonstrate:
* Staff training and education is consistently , including, but not limited to relating to behaviour management and restrictive practices, serious incident reporting, documentation and risk management.

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

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

* The approved provider must demonstrate:
* Accountability for the delivery of safe, inclusive and quality care and promotes and is accountable for a culture of inclusivity.

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

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

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*
* The approved provider must demonstrate:
* Organisational governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints are reviewed and understood by staff, including regular monitoring and oversight of these areas by the governing body.

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

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

* The approved provider must demonstrate:
* Systems for incident and risk management, including compliance with serious incident reporting, are robust and effective.
* Personnel (including management) have a thorough understanding of their obligations in these areas and mastery of an effective incident management system.
* Effective oversight of the risk management system to identify when risk controls need to be reviewed.

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

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

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*
* The approved provider must demonstrate:
* Clinical oversight are reviewed and able to be effective, including in relation to coordinated efforts to minimise restraint, ensure a high standard of antimicrobial stewardship, and consistent practise of open disclosure.
* The Clinical Governance Framework effectively guides the practice of staff and staff can demonstrate these practices in their day to day work.