Marco Polo Aged Care Facility

Performance Report

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**Commission ID:** 0560

**Provider name:** Marco Polo Aged Care Services Limited

**Site Audit date:** 14 June 2022 to 20 June 2022

**Date of Performance Report:** 1 September 2022

# Performance report prepared by

Samantha Hicks, 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) | Non-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) | Non-compliant |
| Requirement 2(3)(c) | Non-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) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Non-compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Non-compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Non-compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **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) | Non-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 taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 1 August 2022.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

Some sampled consumers did not consider that they are treated with dignity and respect, can maintain their identity and make informed choices about their care. Most consumers said staff were kind to them however, some consumers described experiences in which they were not treated respectfully as well as describing circumstances in which their preferences were not always sought or followed. In addition, whilst the service collects information about consumers’ identity and culture, it does not ensure that actions are taken support consumers in relation to their identity, culture and diversity.

The service enables consumers to take risks to enable them to live the best life they can however, assessments and interventions are not developed to support consumers to mitigate the risks.

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

## 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 found that consumers generally felt that staff are kind and caring. However, some consumers described experiences that demonstrated that they are not always treated with dignity and respect. In addition, observations made by the Assessment Team confirmed that this is the case. While the service collects information about consumers’ identity and culture, it does not ensure that actions are taken support consumers in relation to their identity, culture and diversity.

Consumers and representatives mostly spoke positively about their interactions with staff and generally indicated that staff are kind and caring and respectful in their interactions with them. However, some consumers described experiences that were not respectful or dignified. These include wait times for personal care and behaviour management. In addition, staff generally spoke respectfully about consumers, however did not always demonstrate knowledge of, and/or, understanding of their person circumstances and life journey and staff were unable to describe ways in which the individual background and preferences of consumers influences their day-to-day experiences in the service.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional context and supporting evidence to demonstrate compliance with this requirement. The evidence included call bell operations/times and icare documents and these have been taken into consideration. However, these were not enough to completely dispel the findings of the Assessment Team. Some of the explanation given by the Approved Provider did provide additional details to allow a further understanding of consumer circumstance that may have resulted in what the Assessment Team found on the day of the site audit but again this was only in certain instances and there was still evidence as seen by the Assessment Team relating to personal care that remained unqualified.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

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

*Care and services are culturally safe.*

The Assessment Team found that the service did not demonstrate that care and services are culturally safe. The service collects basic information about the consumer’s culture and some information about past traumas. However, the service does not demonstrate that this information informs the delivery of care and services to ensure consumers are culturally safe.

The Assessment Team spoke with lifestyle staff about how consumers from diverse backgrounds are supported and although the Service does attempt to provide culturally appropriate activities it is generalised and less tailored to the consumer preferences. Lifestyle staff said that the lifestyle coordination is fragmented, that there has been no real coordination and leadership for several years and this impacts on the ability of the lifestyle team to meet the cultural needs of consumers.

Some cultural information is obtained and recorded in consumer care planning documentation. However, there is generally no information about how the Service will support consumers in relation to their cultural backgrounds.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional context and supporting evidence to demonstrate compliance with this requirement. The evidence did provide some additional details for the provision of cultural activities for consumers and how COVID 19 had impacted the Service’s ability to provide some cultural activities. However, the details still did not address the predominate issue of the recording and provision of individualised cultural preferences delivered in a culturally safe manner.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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 found that whilst care planning documentation captures some information about consumers’ choices in relation to care and services, consumers are not always supported to exercise these choices. Staff and consumers reported that this can be attributed to low staffing levels. The Assessment Team also found there is a shortfall in processes to involve consumers in their care planning processes with consumers having a limited ability to make and communicate decisions about their care. In addition, the Service also does not have systems to capture and act on consumers’ wishes about who and how the consumer wishes others to be involved in their care and decisions about their care.

The Service does not have a process for consumers to identify the degree to which they wish to be responsible for decisions about their own care and when and how they wish to have others involved. Although the admission process includes the consumer identifying who their next-of-kin and person of responsibility are the process does not extend to include the identification of the degree to which the consumer wishes to independently make decisions about their care or the extent to which they wish to have the person nominated as person responsible or others involved. This was confirmed by a representative who provided feedback that their consumer wished to make all their decision (and was capable to do so) but insisted on the representative making decisions for the consumer.

Information about consumer care choices, for example showering times, is generally recorded in their care plans. However, the Assessment Team observed that much of the information is generic in nature. Consumers also provided feedback that their preferences were often overlooked as staff were too busy. Furthermore, the Service’s current visiting process requires visitors to book a time to visit prior to the day of the visit. Consumers provided feedback to the Assessment Team that this process was impacting their ability to maintain connections with family and friends and did not allow for spontaneous visits from family and friends and maintain relationships with those who are important to them.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional context and supporting evidence to demonstrate compliance with this requirement. The submission did provide some specific context to some of the feedback provided by consumers however it did not provide enough to dispel the feedback provided by consumers/representatives. In addition, the submission also outlined positive steps the Approved Provider had taken since the site audit to return the service to compliance with this requirement however these are ongoing and are not reflective of the level of compliance as seen on the day of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that each consumer is supported to exercise choice and independence, including to:

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

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

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

The Assessment Team found that the service enables consumers to take risks to enable them to live the best life they can however, assessments and interventions are not developed to support consumers to mitigate the risks. For example, although the Service had undertaken some risk assessments on the use of personal electrical items in consumer rooms these assessments were outdated and were not consistently completed for all consumers using these electrical items. In addition, these risk assessments were not updated when there were changes in consumer’s ability or capacity to mobilise.

The Assessment Team found staff did not demonstrate a strong understanding of risk assessment/mitigation in conjunction with supporting consumers to take risks. The Assessment Team noted that risks were only documented for clinical risks but did not consider other risks. In addition, in some instances staff completing risk assessments were not suitably qualified to do so.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The submission outlined positive steps the Approved Provider had taken since the site audit to return the service to compliance with this requirement. Most of the improvements and update have occurred however these some remain ongoing and are not reflective of the level of compliance as seen on the day of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that each consumer is supported to take risks to enable them to live the best life they can.

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

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

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

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

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Most sampled consumers did not consider that they feel like partners in the ongoing assessment and planning of their care and services with most consumers interviewed confirmed that they are not involved in care planning. This was confirmed with care planning documents not reflective of consumer input into clinical/personal care or are consulted at the time assessment and planning decisions are made. In addition, care plans are not always individualised relative to the risks to each consumers health and well-being. Lastly, care and services are not reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

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

## 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 found significant risks that potentially could impact consumers’ health and well-being are inconsistently managed. Risks are not always considered in assessment and planning to inform the delivery of safe and effective care to each consumer. In addition, there has not always been reassessment of consumer risk following incidents.

The care planning documents do not evidence comprehensive assessment and planning for the consumers sampled and are not individualised relative to the risks to each consumers health and well-being. The Assessment Team saw inconsistencies with consumer information and care strategies which meant consumer plans were not accurate which in turn leads to compromised care provision. There were also discrepancies found in care plans after consumers returned from hospital.

The organisation has written materials that support staff to undertake assessment and planning. The computerised documentation system has an alert system to inform staff when assessments are due. However, these alerts are not actioned in a timely manner.

In contrast, clinical staff interviewed could describe the assessment and care planning process. They said they gather information from staff, consumers and their representatives during admission and when the care plan is developed it is sent to the representatives in an email.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional context and some supporting evidence. However, these were not enough to completely dispel the findings of the Assessment Team and the Approved Provided did acknowledge some of the deficiencies identified by the Assessment Team. Therefore, the Approved Provider cannot demonstrate that assessment and planning, consistently and accurately, informs the delivery of safe and effective care and services.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

### Requirement 2(3)(b) Non-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 found that some consumers and their representatives expressed concerns that consumers’ needs are not adequately addressed and are impacting on their health and wellbeing. There was consistent evidence found by the Assessment Team where consumers’ needs, and preferences are not identified or addressed in accordance with the consumer’s expressed wishes or in a timely manner.

For most consumers sampled, the care planning documents did not detail consumer’s current needs, goals and preferences. For example, assessments are not always undertaken following skin integrity issues and contributing factors are not recognised so needs, preferences and goals regarding wound management are not identified for some consumers. Deterioration post incident was another area which was inconsistent in reflecting current needs.

Although the documents reviewed by the Assessment Team had inconsistencies clinical staff interviewed could describe how they capture consumers’ needs, goals and preferences for care and services through the admission assessments, when there is change in their condition and questions they ask consumers about how they would prefer care and services. They were also able to describe some specific consumer’s preferences and goals including in relation to end of life care and encouraged the completion of advanced care directive on entry to the service, during case conferences or when care plan is reviewed.

For sampled consumers most had end of life information including advance care directives. Care planning documents reviewed for palliative consumers included end of life planning including consumer’s wishes and advance care directives. Representatives interviewed indicated staff have spoken to them about advance care and end of life planning. They felt care and services were delivered in a way that respected consumer needs and preferences in relation to end of life care.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional context and some supporting evidence. It is acknowledged the Approved Provider has demonstrated compliance with regards to advance care planning and end of life planning. However, although the Approved Provider has submitted some clarification relating to consumer preferences issues remain with consistency and accuracy in relation to capturing consumer needs, goals and preferences.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

### Requirement 2(3)(c) Non-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.*

The Assessment Team found that for some consumers sampled, the service did not demonstrate the assessment and planning processes are undertaken in partnership with consumers or their representatives. Processes, including case conferences are intended to identify consumers’ wishes however this has not occurred for most consumers sampled. Assessment and care planning do not demonstrate goals, needs and preferences are consistently established by consumers themselves.

The Assessment Team reviewed all the completed care plan consultation forms and only a small proportion of consumers had a completed form. In addition, for the consumers sampled, care planning documents do not reflect that the consumer and other providers and/or organisations are involved in assessment and planning.

Some feedback received from representatives mentioned that information was provided by the Service staff however, they did not feel like they have an active partnership in the development of her care plan.

Management said they acknowledge that case conferences and care planning has not been occurring. They are working to rectify this and included it in the continuous improvement plan.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing details of actions taken since the site audit to rectify some of the issues identified by the Assessment Team. However, this does not dispel the findings of the Assessment Team on the day of the site audit when the Approved Provider could not demonstrate partnerships formed a part of assessment and planning.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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 found that the Service did not always demonstrate that outcomes of assessment and planning for each consumer have been effectively communicated with the consumers or their representative as per consumer’s wishes. Some consumers and representatives sampled provided feedback that supports they are not aware they had access to the care plans.

The computerised documentation system has a care plan format which automatically converts assessments into the care plan. Care plans are retained in the computerised documentation system that can be downloaded and printed in the extended format or a summary. However, feedback from consumers/representatives in relation to the communication of assessment and planning was not consistent. The Assessment Team also found that there is no consistent record of this process and it was not evident that consumers and representatives have been provided with access to their care plans.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional information and care plan evidence. It is acknowledged that the Approved Provider has provided care plans to some consumers and representatives. However, there was clear evidence from the Assessment Team that there is inconsistency in the communication of assessment and planning.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

### Requirement 2(3)(e) 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 whilst some care plans for consumers sampled are reviewed, the plans for several consumers did not identify whether interventions have been effective in meeting their needs. There are no investigations when incidents occur and strategies to minimise reoccurrences are not always identified or appropriately actioned and recorded in care plans.

For the consumers sampled, the care plans do not show evidence of review on both a regular basis and when circumstances change, or when incidents occur. The Assessment Team found that were at a number of plans that have not been reviewed in the past 6 months and there were a number of overdue care plan evaluation alerts in the electronic care system. In addition, there were missed weekly progress notes.

For example, for one consumer changes in their health condition did not trigger an effective review of his care plan for increased care needs involving personal hygiene and skin care management resulting in poor quality outcomes for the consumer. In addition, regular review of restrictive practices for many consumers were not occurring.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional context and some supporting evidence. It was noted the context provided for some consumer feedback. It is also acknowledged that improvements have been made and are ongoing in relation to assessment and care planning. However, these were not enough to evidence to dispel the findings of the Assessment Team and the improvements made after the date of the site audit are not reflective of the Service at the time of the audit. Therefore, the Approved Provided cannot demonstrate that care and services are consistently reviewed for effectiveness.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

# STANDARD 3 NON-COMPLIANT Personal 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Most sampled consumers did not consider that they receive personal care and clinical care that is safe and right for them with some consumers/representatives providing details of issues regarding personal hygiene and clinical care management.

Concerns were raised by consumers/representatives about the deterioration of their family members and incident management. The Assessment Team found that there had been incidents of high impact and high prevalence risks which have not had adequate review to improve outcomes for consumers.

The service was not able to demonstrate it delivers safe and effective personal and clinical care in accordance with the consumer’s needs, goals and preferences to optimise their health and wellbeing. Deficits were identified in skin care, falls management, restrictive practices.

The comfort of consumers nearing the end of life is maintained and their needs, goals and preferences are recognised and addressed.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that clinical care provided is not best practice or optimises the consumer’s health and wellbeing. This was based on consumer/representatives’ feedback about aspects of clinical and personal care and the review of care and services records for consumers sampled. Particularly there were issues in responding to and providing care when the consumer’s condition changes and recognition and response to changes in skin integrity. Issues were also identified in relation to restrictive practices, including chemical, environmental and mechanical restraints, which have not been managed or used as a last resort to optimise consumer wellbeing.

The care documentation for most of the consumers sampled do not reflect individualised care that is safe, effective and tailored to the specific needs and preferences of the consumer. For example, care plans not being updated post hospital stay resulting in poor care upon return. Restrictive practices being continued after return from hospital with no evidence that review for the need for this medication, and no psychotropic medication review or update in the care plan. In addition, there was no further monitoring of this injury in care and services documents post hospital stay either.

The Assessment Team found that the Service has not demonstrated best practice, in diabetes management, behaviour management particularly in relation to meaningful activities to help manage behaviour and emotional support. In addition, deficiencies were identified where alternatives to restrictive practices were not actively explored or trialled. In these areas care was not tailored to consumer’s need and does not always optimise consumer wellbeing.

A representative had mixed feelings about the Service and the level of care. Behaviour management and support and medication usage were of concern. Another representative spoke of great staff, but said they are understaffed and not adequately trained to care for consumers with dementia and this leads to increased aggression and behavioural issues with their consumer as well as use of psychotropic medications unnecessarily. Other representatives spoke of issues in relation to wound identification and care and involvement in care planning.

The Approved Provider submitted a detailed response relating to the findings of the Assessment Team providing additional context, clarification and some supporting evidence. It was noted that some of the information did provide clarification of some individual consumers circumstances. It has also been noted that some attention has been given since the day of the site audit to improve behaviour support. However, there is not enough to evidence to dispel the overall findings of the Assessment Team and the improvements made after the date of the site audit are not reflective of the Service at the time of the audit. Therefore, the Approved Provided cannot demonstrate each consumer consistently gets safe and effective care.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated thateach 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.

### 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 found that the service does not demonstrate that high impact or high prevalence risks associated with the care of consumers is effectively managed. Incidents are not always reported. Incidents are not investigated to identify contributing factors and measures to prevent future incidents are not developed. For example, the Assessment Team found for one consumer that there was no review of whether existing falls prevention measures are effective or the development of new interventions.

Furthermore, The Assessment Team found that there were shortfalls in the management of high prevalence high impact risks for pain management, behaviour support, wound management and skin care. Most notably there were shortfalls for several consumers in relation to falls preventative strategies. The Assessment Team found in some cases strategies for falls prevention were generic and not effective to prevent further falls.

The Assessment Team also had feedback from representatives expressing concern about the high number of falls with the Service not doing enough to prevent further falls to the detriment of their consumers care. However, representatives also had positive feedback relating to involvement in care planning contacting them after incidents and regarding medications.

Nursing staff said they required training in falls prevention, dementia and behaviour management and stated that staffing levels impact their ability to provide supportive and preventative measures for consume care. In addition, the Assessment Team reviewed the accident/incident report register and falls committee meeting minutes. The service management said they conduct these meetings monthly, however, only meeting minutes for two months this year were found. In contrast, management did however state falls meeting with the physiotherapist are held monthly and all consumers are reviewed by physiotherapist after a fall and this was confirmed by some consumers.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing additional clarification and supporting evidence. Whilst the clarifications did dispel some of the Assessment Team’s findings it did not address all the findings relating to the consumers sampled. It has been noted that some of the information did provide clarification of some individual consumers’ circumstances. The Approved Provider has not been able to demonstrate that high prevalence and high impact risks are consistently considered and managed effectively to improve quality care outcomes for consumers.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that effective management of high impact or high prevalence risks associated with the care of each consumer.

### Requirement 3(3)(c) Non-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 that the needs, goals and preferences of consumers who have been commenced on an end of life pathway are captured. Consumers are kept comfortable and their dignity is preserved. However, the service does not demonstrate that actions are taken to in a timely manner to identify any possible causes for rapid deterioration prior to taking steps to commence end of life care. In addition, there were examples where consumers were not assessed in a timely manner to attempt to have an unwell consumer seen by a medical officer prior to commencing palliative care. This mostly occurred when situation arose after-hours.

Representative feedback was mostly very positive about the end of life care. Representatives said staff were very kind and caring and that their loved ones were cared for very well and kept comfortable. However, some representatives raised concerns about the communication with the lack of case conferences.

Clinical management said staff monitor the ongoing condition of consumers and as signs of deterioration are noted, they have a case conference with the family and ask for preferences, giving them options on what pathway to follow. In addition, the Service always involve the palliative care team when consumers are on an end-of-life pathway.

The Approved Provider did not submit a response relating to the findings of the Assessment Team. It is acknowledged that consumers once on a palliative are provided with quality care. However, based on the findings of the Assessment Team improvements need to be made in the initial stages and where rapid deterioration is occurring. Therefore, the Approved Provider has not been able to demonstrate fully that consistent quality care is provided for end of life pathways

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

### Requirement 3(3)(d) 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 that deterioration in consumer condition is not always recognised and responded to in a timely manner. There have been negative impacts to consumers due to lack of effective clinical oversight in relation to the deteriorating consumer. In addition, review of care planning documents showed deficits in identifying and managing deterioration in consumers in a timely manner.

From the consumers sampled there were instances where a change mental health for a consumer was not supported with a decline in consumer ability. Supports post hospital visits were also inconsistent including minimal pain reviews and putting mechanisms in place to assist with mobility.

Consumer/representatives on their behalf provided mixed feedback regarding the service’s response when a consumer’s condition deteriorated, or they experienced a change. Representatives said they were not always informed of changes or incidents. Some representatives said they are the ones who identify changes in the consumer’s condition.

The Approved Provider submitted a detailed response relating to the findings of the Assessment Team providing additional context, clarification and some supporting evidence. It was noted that some of the information did provide clarification of some individual consumers circumstances and care provided. However, there is not enough evidence to dispel the overall findings of the Assessment Team. Therefore, the Approved Provided cannot demonstrate consistent care for consumers that are deterioration or have a change in condition.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

### Requirement 3(3)(e) 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 that assessments and care planning documentation is not always reflective of consumers’ current care needs and preferences, and they do not provide effective information to assist staff to meet those needs and preferences. Some representatives reported that communication in the service is poor, and they need to repeat information about the consumer and their care needs multiple times.

Assessments and care planning documentation is not always reflective of consumers’ current care needs and does not support staff having current information to guide them in relation to meeting consumers’ needs and preferences. For example, skin tears and bruises were not updated in care plans to identify goals and preferences to inform care delivery and care plans showed inconsistent practice with the use of appropriate precautions during wound care.

Management indicated that emails are sent to all staff regarding changes in care plans, handover each shift. They said palliative process involve all clinical team including medical officers. However, they said there is a gap in communication with agency staff as they cannot access email messages.

The Assessment Team noted care alerts for consumers to guide care and service delivery including prompts for care plan evaluation, blood glucose testing and reviews for allied health. However, these alerts are not always actioned in timely manner.

The Approved Provider submitted a response relating to the findings of the Assessment Team however, it did not dispel he Assessment Team’s findings. Therefore, based on the evidence the Approved Provider has not been able to demonstrate that consumer needs and preferences are consistent and effectively communicated within the organisation or where care is shared.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

### Requirement 3(3)(f) Non-Compliant

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

The Assessment Team found that the service does not always ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services. This includes in relation to behaviour support services and medical officers. The Assessment Team found that there were delayed referrals in relation to deterioration, behaviour support, clinical care. Representatives also provided feedback that the Service had not followed through on some referrals for care located outside of the Service. In addition, management acknowledged some issues relating to access to afterhours medical officers.

The Approved Provider submitted a brief response relating to the findings of the Assessment Team however, it did not dispel he Assessment Team’s findings. Therefore, based on the evidence the Approved Provider has not been able to demonstrate that a timely referral process to meet consumer care needs.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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 found that the service has policies and procedures relating to infection control prevention and management and antimicrobial stewardship. Whilst there were some minor issues with infection control identified by the Assessment Team these were rectified at the time of the audit. In addition, for the sampled consumers who have experienced infections, their representative provided positive feedback regarding the management of their infections. They said they are satisfied with the service’s response to the symptoms and were satisfied with the care and management of consumers during the COVID-19 outbreak.

Clinical and care staff demonstrated sufficient knowledge of current infection control practices and outbreak plan. Care staff stated the importance of fluid encouragement and proper hygiene care for the prevention of infection. In addition, clinical staff were able to describe antimicrobial stewardship and stated they inform medical officers to request a clinical specimen when they identify signs of infection, prior to the prescription of antibiotics.

The Approved Provider submitted a response relating to the findings of the Assessment Team. There was detail explanation for some of the infection control issues that were noted on the day of the site audit with satisfactory explanation. In addition, the Service acted quickly to rectify anything that was spotted by the Assessment Team on the day of the audit. Taking this into consideration the evidence demonstrates that the Approved Provider is committed and active in minimising the risks of infection to consumers.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated thatminimisation of infection related risks through implementing:

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

# STANDARD 4 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service and staff were asked about their understanding and application of the requirements. The team also examined relevant documents.

Most sampled consumers did not consider that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers also said there are insufficient things to do or the things on offer are not of interest to them. In addition, some consumers/representatives said there are some issues with being able to visit when preferred and being supported to maintain contact with loved ones.

The Service did not enable consumers to receive safe and effective services and support for daily living which meet their needs, goals and preferences and optimises their independence. In addition, consumers’ emotional, and psychological well-being was not promoted, and consumers were not supported to undertake activities of interest to them.

The service does not have effective systems to capture and communicate information about consumers’ condition, needs and preferences and does is unable to demonstrate that appropriate referrals are made to individuals, other organisations and providers of care.

Negative feedback was received from many consumers interviewed about meals. The quality and variety of the food has been an ongoing issue at the service. However, where equipment is provided, it is safe, suitable, clean and well maintained.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-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 found that the service does not ensure that each consumer gets safe and effective services and supports for daily living. The Assessment Team identified deficiencies in consumers receiving safe and effective services and support for daily living which meet their needs, goals and preferences and optimises their independence, health, well-being and quality of life. Consumers’ emotional, and psychological well-being is not promoted, and consumers are not supported to undertake activities of interest to them.

Multiple consumers said they are bored, the activities offered are not of interest to them and they would like to be able to go out more. One representative said that their loved one has been unable to be outdoors, walking and gardening since COVID-19. As a result, they spend most of their time in their room and has led to increased boredom and anxiety. Another representative said COVID-19 meant that some things could not be done but the Service has not looked at how to be creative and provide more meaningful ways to keep consumers engaged and prevent feeling isolated; as a result, nothing has been happening and consumers are not engaged.

Furthermore, the service still requires bookings to be made in advance if family want to visit her and this limits the opportunity for spontaneous visits. Feedback to the Assessment Team means representatives cannot visit if they find free time unexpectedly during the day. The Representative said that this contributes significantly to her overall unhappiness with being at the service. In addition, the representative felt that their loved one had lost independence both in terms of being able to be out and about, do things that interest her and in general have control of her life.

Care planning documents include some information about consumers lives but limited information about their cultural and spiritual needs. Information about things that consumers would like to do is largely limited to the options provided by the service’s group activity program rather than being linked to the consumers interests. Where interventions are recorded in assessments and care plans, many activities no longer occur. In addition, some individual interventions such as walking outside the building with consumers and room visits rarely occur.

Management said they had identified that improvements need to be made to the lifestyle program in terms of content of the program and the tasks which lifestyle staff take on. Management confirmed they have commenced working with the lifestyle staff to address the issues with the program. Lifestyle staff said lifestyle activities have been reduced due to staff members being away. In addition, lifestyle staff said there is currently no lifestyle coordinator, and this has meant no-one has been coordinating lifestyle programs. Staff said that consumers really want is to be able to get off the bus during outings and to go shopping but this is difficult due to staffing levels.

The Approved Provider submitted a detailed response relating to the findings of the Assessment Team providing additional context, clarification and some supporting evidence. It was noted that some of the information did provide clarification of some individual consumers daily living circumstances and heir quality of life. However, with consistent feedback from consumers/representatives and staff especially in relation to activities there is evidence to suggest improvement is warranted to ensure consumers have the quality life they want that is individualised and delivered consistently.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.

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

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

The Assessment Team found that the services and supports for daily living do not promote each consumer’s emotional, spiritual and psychological well-being. Limited information is collected about consumers’ spiritual preferences and needs and there are limited interventions to support consumers in their spiritual needs. In addition, the experiences of consumers in the service impacts on consumers’ emotional and psychological well-being. There is also no evidence that consumers are provided with emotional support during difficult periods such as when moving into the service, following traumatic incidents, during or following periods of illness or illness of loved one.

No documentation was observed to demonstrate that assessments of consumers' emotional and psychological well-being is undertaken following incidents involving aggression and assault by other consumers. There is also generally no documentation to demonstrate that emotional support is provided.

The service does not have a comprehensive list of consumer's faiths and while the consumer's faith is sometimes recorded in care plans this does not occur for all consumers.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing some additional context and supporting evidence. Whilst it did provide some additional context and outline some actions that have been taken since the day the evidence as seen by the Assessment team still shows an ongoing systemic issue with the provision of emotional and psychological care and service for consumers.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

### Requirement 4(3)(c) Non-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 found that the service generally supports consumers to have social and personal relationships. However, some consumers and representatives believe the requirement to book visits impacts on their ability to maintain relationships. The service does not support consumers to participate in the community outside the service environment. The service does not have a varied program of activities and consumers are not involved in the program. There is limited support to assist consumers do things of interest.

Some consumers said they can pursue their interests however; many consumers did not feel they have enough interesting things to do. Some indicated that they would like more variety. Some consumers felt there had been a decline in the amount and variety of activities on offer particularly in relation to external outings.

Many consumers’ care plans refer to them currently undertaking activities which have not occurred for an extended period. In addition, activity participation records generally do not demonstrate that consumers are able to pursue activities of interest to them.

The Assessment Team observed consumers throughout the site audit sitting for long periods of time with limited engagement. They also found the calendar did not include all activities which means consumers are not aware of all activities and that activities were often cancelled. In addition, the Assessment Team did not observe any documentation to indicate that consumers have been consulted and involved in the development of the lifestyle program. Lifestyle staff confirmed that this was the case.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing some additional context and supporting evidence. It is noted that the Approved Provider has been able to demonstrate that they generally support consumers to have social and personal relationships. However, whilst it is acknowledged that COVID-19 may have had some impact on the ability to provide certain activities it does not provide sufficient evidence to dispel why consumers are not fully engaged in a variety of activities to have a sense of community. Even in an COVID-19 outbreak, consideration must be given and provided to consumer daily living engagement and the things that interest them. Therefore, the Approved Provider cannot demonstrate completely that they adequately and consistently supply services and supports for daily living assist each consumer.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated thatservices and supports for daily living assist each consumer to:

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

### Requirement 4(3)(d) Non-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 found that the service does not have effective systems to capture and communicate information about consumers’ condition, needs and preferences. The Assessment Team identified that there were a number of non or miscommunications in association with consume care and support provided by providers external to the organisation. In addition, care planning documentation for sampled consumers had limited information about consumers goals, preferences and interventions and that care planning documentation was not always reflective of consumers’ current situation.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing some additional context to include how some representatives had taken over the responsibility for some of the communication with external care/support providers. However, this does not indicate that the Service should not have the relevant information or seek the relevant information so that consumer’s condition, needs and preferences is communicated effectively within the organisation to ensure quality outcomes for consumers. The Approved Provider did acknowledge that improvements were warranted in this area.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

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

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

The Assessment Team found that the service is unable to demonstrate that appropriate referrals are made to individuals, other organisations and providers of care. Care planning documents for sampled consumers did not reflect the involvement of others in the provision of lifestyle supports. However, in contrast management said that referrals had been made in relation to medical services.

The Approved Provider submitted a response relating to the findings of the Assessment Team providing a comprehensive list of all the services that consumers are referred to for other care and services. It is also not effectively substantiated by the Assessment Team that there is a systemic issue with the amount, appropriateness and timeliness of consumer care referrals. Therefore, based on these two contributing factors the Approved Provider has been able to demonstrate that they do actively refer consumers to other care providers.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated that 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 found that overall feedback about meals was that it is not sufficiently varied or high quality. No consumers/representative provided positive feedback about meals. Feedback from consumers included lack of variety, the way the food is cooked and the food being of poor quality. One consumer was even choosing not to eat the food and eat the food he has in his room. In addition, the Assessment Team noted that consumers indicated they have been dissatisfied with meals for a long time. Management said a new chef is commencing soon and they hope this will improve satisfaction with meals.

Catering staff were interviewed by the Assessment Team and they could describe the feedback mechanisms which include feedback forms, a food focus group and verbal feedback at meal times. They confirmed that there has been a lot of negative feedback. In addition, catering staff could explain specific dietary needs and preferences for consumers sampled. They advised nutrition and hydration care plans were communicated to the catering staff and hard copies are contained in folders for reference if required.

Catering staff were observed by the Assessment Team to be wearing required personal protective equipment and following work health and safety requirements. The main kitchen and kitchenettes were clean and tidy with plenty of room in the storage room and other areas.

The Approved Provider submitted a response relating to the findings of the Assessment Team. However, the Approved Provider response only provided minimal context which in turn did not dispel the finding so of the Assessment Team.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that where meals are provided, they are varied and of suitable quality and quantity.

### Requirement 4(3)(g) Compliant

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

# STANDARD 5 NON-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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The team also examined relevant documents.

Overall sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. Consumers/representatives said the consumer’s family and friends are made to feel welcomed when they visit.

Consumers said they are mostly satisfied with the cleaning services. They confirmed that they can place personal items in their rooms and furniture is placed in the room according to their preference and to make their rooms as comfortable as possible.

While the interior of the service is generally clean and well maintained, aspects of the service environment were dirty and not well maintained. Some environmental risks are not assessed, and some consumers are unable to move freely between indoor and outdoor areas. In general, however, furniture, fittings and equipment in the service environment is safe, clean and well maintained.

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

## Assessment of Standard 5 Requirements

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

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

### Requirement 5(3)(b) Non-compliant

*The service environment:*

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

The Assessment Team found that the interior of the service is generally clean and well maintained. However, aspects of the service environment were dirty and not well maintained; particularly outdoor areas. In addition, some consumers are unable to move freely between indoor and outdoor areas.

While most of the indoor areas were observed to be clean, the Assessment Team observed that a room between the nursing home lounge and the courtyard was dirty and dusty. Some outdoor furniture was poorly maintained including chairs. However, consumers feedback was positive about the environment, and consumers and visitors confirmed they were satisfied with the cleanliness of the service. Consumers and representatives said if anything needed fixing, they would report it to staff. Consumers also said the cleaners were very good and maintained a clean environment in their rooms and communal areas.

Management said they were aware that aspects of the service environment required maintenance and this work has been scheduled. They also stated that the organisation is embarking on a renovation project as well.

The service has a preventative maintenance program in place for buildings, furniture, equipment and fittings, and systems to cater for hazards and reactive maintenance where appropriate. When the environment needs maintenance, it is attended to appropriately. The maintenance log evidences maintenance is logged and carried out in a timely manner. A review of the log found no outstanding maintenance issues that impact on consumers. The call bell system is reviewed monthly and is part of the preventative maintenance program.

At the Service there is an open internal staircase with a lift next to it. Consumers are advised to use the lift and not the staircase. However, there are many consumers who may use this area living with cognitive impair and may be at risk of using the stairs. No risk assessments had been undertaken in relation to risks it might pose for some consumers.

Some consumers are unable to move freely between indoors and outdoors. There is a sliding door in the lounge room which was locked when checked on three occasions throughout the site audit. The door also had a curtain pulled across and a bird cage in front of the curtain. The back door of the unit is a fire door which was observed to be closed but unlocked throughout the site audit. The door is not recognisable as a door for consumers or visitors to exit through; it has the appearance of a restricted access area. No consumers were observed using the courtyard in this area for the duration of the site audit.

Other consumers are environmentally restricted and unable to exit the service due to the installation of keypad entry/exit. Only those consumers who are able to remember the code could independently exit the service.

The Approved Provider submitted a detailed response relating to the findings of the Assessment Team providing additional context and circumstantial information. It is acknowledged that the Service overall is safe, clean, well maintained and comfortable. Consideration has been given to the constant poor weather conditions prior to the audit which made it difficult to maintain outdoor areas. On reflection this does not prove a systemic issue with the safety of the environment. However, there were issues identified with consumers being able to move freely indoors and outdoors and although weather may have impacted the consumers it was not so extreme as to warrant consumers losing the ability to move freely between indoors and outdoors. Therefore, the Approved Provider has been unable to demonstrate compliance to all components of this requirement.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – asking them about how they raise complaints and the organisation’s response. The team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Overall sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and that the service works with them to address concerns. The Service also has systems to inform and support consumers in providing feedback and complaints. In addition, the Service assists with advocacy and translation services where needed.

Not all complaints are captured in the service’s complaint system. However, appropriate actions are taken in response to recorded complaints and actions taken to make improvements because of complaints being raised.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

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

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

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

### Requirement 6(3)(c) Compliant

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

### Requirement 6(3)(d) Compliant

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

To understand the consumer’s experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Majority of sampled consumers considered that they do not receive quality care and services when they need it and from staff who are knowledgeable and capable. The roster has ongoing unfilled shifts with most consumers and representative saying that the service is short staffed and could provide examples how this impacts them.

Staff are generally kind and care towards consumers. However, the service does not demonstrate that the workforce is planned and the number and mix of deployed members enables the delivery and management of safe and quality care and services.

While members of the workforce have the necessary qualifications to undertake their roles, the Service did not demonstrate that staff have the knowledge and skills to effectively perform their roles. Training and support for staff and not been effective in ensuring staff have the necessary knowledge and competence to undertake their roles. The Service does however, have a system for monitoring and review of staff performance.

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

## 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 found that the service does not demonstrate that the workforce is planned and the number and mix of deployed members enables the delivery and management of safe and quality care and services. There are a large number of unfilled shifts each week and the majority of consumers consistently reported there are insufficient staff which results in the care not being provided in a timely manner including staff rushing their care and not having time for them. Multiple staff including care and lifestyle staff report that they are unable to effectively meet consumers’ needs, goals and preferences because of there being insufficient staff. For example, once consumer said the nursing staff are accommodating and work hard but the service is understaffed. The Assessment Team also saw that staff were finding it difficult to manage personal care and an assisting consumer with meals.

Furthermore, staff confirmed they are not always able to get consumers up when the consumer wants to because of a lack of staffing with competing priorities. Care staff also confirmed they often work with less staff and as a result they are not providing care in line with the consumer’s preferences. In addition, the Assessment Team confirmed that most days there are unfilled shifts and most of the time they are understaffed even with staff extending their hours.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider is whist giving some context to the staffing situation the Approved Provider did acknowledge that there is staffing concerns. Based on this and the evidence found by the Assessment Team that staffing is not suitably enabled to ensure positive care outcomes for consumers.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

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

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

### Requirement 7(3)(c) 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 found that the members of the workforce have the necessary qualifications to undertake their roles. However, deficiencies in the workforce’s knowledge and skills were identified. These include undertaking thorough assessment and planning in relation to consumers’ personal and clinical care and the delivery of care clinical and personal care. For example, deficiencies were identified in staff knowledge and skills in relation wound care, pain management, falls prevention and behaviour management. There were also deficiencies found in the knowledge in relation to the implementation of the SIRS and incident management

In relation to staff qualifications the Assessment Team found that the organisation has documented core competencies for different roles at the service. Staff have access to position descriptions across all roles at the service. A record of qualified staff is monitored by management to ensure they are still current. These were observed to be in orientation packages and personnel files.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider response did give some context and scheduled training in relation to improving the knowledge based of staff. It is also acknowledged that the Approved Provider does has a working system to ensure staff are suitably qualified and these qualifications are maintained. However, The Assessment Team did provide evidence that the knowledge base of staff requires improvement and the current skill level has impacted consumer care.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

### 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 found that the organisation although having systems in place to ensure the workforce is recruited appropriately shortfalls were identified in some training areas. Consumers spoke of staff not being trained in caring for people with dementia and at they are not competent at behaviour management.

Management said the Service uses feedback from consumers and representatives, clinical indicators and incidents and performance reviews to identify staff training needs however staff said they have not had training in falls prevention, dementia and behaviour management. Consumer feedback and staff surveys are also conducted to receive feedback on training needs however, this was not evident in documentation reviewed by the Assessment Team.

The service demonstrates that an education program is in place which includes a wide range of mandatory and elective education topics. However, deficiencies identified during the site audit demonstrates that training and support that is being provided to staff is not effective in ensuring staff have the necessary knowledge to undertake their roles.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider did provide some additional information in relation to staff training however this did not completely dispel the findings of the Assessment Team particularly in relation to dementia training and how consumers are being impacted due to a shortfall in staff competencies.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

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

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

# STANDARD 8 NON-COMPLIANT Organisational 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

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Most sampled consumers did not consider that the organisation is well run and that they can partner in improving the delivery of care and services. The Organisation does not have processes to engage consumers in the development, delivery and evaluation of care and services. Due to this it was identified that the governing body is not accountable for service delivery and Issues were identified in relation to the implementation of the organisation clinical governance framework.

The organisation is unable to demonstrate that it has effective governance systems in relation to information management, continuous improvement activities, workforce governance and regulatory compliance. The organisation does have policies and procedures in relation to risk management however, deficiencies identified during this site audit show that the procedures are followed to ensure risks are identified and managed.

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

## Assessment of Standard 8 Requirements

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

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

The Assessment Team found that the organisation does not have processes to engage consumers in the development, delivery and evaluation of care and services. In addition, there are no policies, procedures or other documents to support the adoption and implementation of practices to actively engage consumers in the development, delivery and evaluation of care and services.

The Assessment Team was unable to evidence regular consumer meetings and management confirmed consumers were not involved in running of consumers meetings when they did occur. There was also little evidence of regular surveys or other mechanisms to gather information from consumers about their satisfaction with the service and organisation.

The Approved Provider submitted a response relating to these findings of the Assessment Team including documented evidence. Although some evidence did provide information in relation to consumer involvement in meetings and newsletters this did not provide the necessary evidence to show co-ordinated, meaningful consumer engagement that is effective to ensure consumers have input into the development, delivery and evaluation of their care and services. In addition, the Approved Provider acknowledges that the Assessment Team had identified some issues and have a plan for improvements. Therefore, based on the findings of the Assessment Team the Approved Provider has not been able to demonstrate consistently that they effectively engage consumers to develop, deliver and evaluate the care and services that are provided to them by the Service.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

### 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 told by Management that the Board had identified that improvements in organisational governance are needed. This was also evident through the deficiencies found across the Quality Standards at the Service. These deficiencies show that the governing body does not effectively support the provision of a culture of safe, inclusive and quality care and services or that the governing body is accountable for their delivery.

The Board had identified that improvements were required in organisational governance. Some of these improvements included having one Board operate for the Service rather than the current two Board model that do not have a co-ordinated approach. In addition, recruitment processes are underway for new more suitable directors. A clinical subcommittee is also being introduced to improve clinical oversight. Part of the improvement in relation to clinical oversight has been the appointment of the executive clinical manager to improve oversight of clinical care across the residential services and report to the clinical subcommittee and Board.

The Approved Provider submitted a response relating to these findings of the Assessment Team. The response predominately outlined plans for improvement actions that the Approved Provider has already taken since the site audit to improve issues related to this requirement. Therefore, based on the findings of the Assessment Team and by the acknowledgment of Management of deficiencies in the organisation’s governing body the Approved Provider has been unable to demonstrate that governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

### Requirement 8(3)(c) 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 that the organisation was unable to demonstrate that it has effective governance systems in relation to information management, continuous improvement activities, workforce governance and regulatory compliance.

The organisation’s information management system was not effective in identifying and communicating information regarding consumer’s personal, clinical and lifestyle needs and preferences within the service and with other relevant individuals and providers of care. For example, review processes for care planning did not identify that appropriate steps are taken to identify contributing factors to incidents which impacts on the development on effective interventions to prevent future incidents.

Management said that opportunities for improvements are identified through audit processes and feedback forms but there was minimal transfer to a robust continuous improvement plan. Furthermore, deficiencies identified across the Quality Standards demonstrates that the organisation systems and processes for continuous improvement have not been effective.

Issues identified during the site audit in relation to sufficiency of staff, staff competency and knowledge and the effectiveness of staff training, support and monitoring demonstrate that governance systems in relation to workforce management have not been effective.

In relation to regulatory compliance the Service tracks changes to aged care law through peak body membership and monitoring information from the Commission. All managers received this information. The process used to communicate any changes to staff has been that the chief executive officer identifies the changes and discusses changes needed with the leadership team. Training materials, both on-line and face to face are developed and implemented when changes occur. This was the process was followed in relation to both new restraint requirements and introduction of SIRS/IMS requirements. However, despite these actions the Assessment Team found deficiencies in relation to restraint management and SIRS/IMS.

The organisation has a system of ensuring that consumers have ways of providing feedback and are advised of these mechanisms, including access to external complaint avenue and support services, such as advocacy services, to assist them in raising complaints. Complaints are appropriately investigated and responded to and improvements made because of feedback.

The Approved Provider submitted a response relating to these findings of the Assessment Team. The response outlined issues the Approved Provider has been experiencing with management changes and acknowledged that this has contributed to the shortfalls as noted by the Assessment Team. Therefore, based on the findings of the Assessment Team and by the acknowledgment of Management of deficiencies in the organisation’s governing body the Approved Provider has been unable to demonstrate that governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that there are effective organisation wide governance systems relating to the following:

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

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

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

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

The organisation has policies and procedures in relation to risk management. However, deficiencies identified during this site audit show that the risk management systems and practice are not adequately followed to ensure risks are identified and managed.

Deficiencies in relation to clinical oversight and incident management result in high impact or high prevalence risks associated with the care of consumers not being identified or effectively responded to. This includes wounds not being identified and responded to in a timely manner and a lack of analysis of incidents to identify contributing factors to prevent future incidents.

Incidents involving consumers by other consumers are not thoroughly investigated to identify contributing factors and changes. In addition, effective, individualised preventative measure are not implemented and monitored. There are also deficiencies in officially reporting incidents and having effective risk management systems and practices for identifying and responding to abuse and neglect of consumers. Overall, there were shortfalls in effective risk management systems to allow consumers to live the best life they can.

The Approved Provider submitted a response relating to these findings of the Assessment Team. It is noted that there is a risk register at the Service however the evidence was unable to show how it is effectively used in relation to the care of consumers. Therefore, based on the findings of the Assessment Team the Approved Provider has been unable to demonstrate effective risk management systems and practices.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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.

### 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 the organisation is in the process of implementing a clinical governance framework which has included the recent appointment of an executive clinical manager and the implementation of a clinical monitoring system that will include trending and benchmarking. However, a review of clinical care during the site audit demonstrates that the current systems for clinical governance are not effective in providing safe and quality clinical care.

Issues related to the clinical governance system were discussed with management. They said they are aware the auditing system is not working effectively, and this is why the organisation is moving to a commercial system that will enable better analysis, trending and benchmarking.

The service has policies and procedures relating to infection control prevention and management and antimicrobial stewardship. However, the service did not adequately demonstrate appropriate infection control practices to minimise infection related risks and transmission of infections. The service also has policies and procedures about minimising the use of restraint. However, the knowledge of staff and management about minimising the use of restraint is limited and deficiencies were identified in relation to environmental and chemical restraint.

Lastly, staff and management generally demonstrated an understanding of open disclosure. However, open disclosure was not exercised in relation to all incidents.

The Approved Provider submitted a response relating to these findings of the Assessment Team. There was evidence provided to show that the Approved Provider does have protocols in relation to antimicrobial stewardship which was satisfactory to meet this component of the requirement. However, based on the findings of the Assessment Team the Approved Provider has been unable to demonstrate effective and consistent clinical governance framework is operational particularly in relation to restrictive practices.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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.

# 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)

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

* Investigate the feedback relating to the provision of personal care.
* Ensure staff are treating all consumers with respect and dignity and if time pressures/staff availability are the cause that this is investigated and improved so staff can have the ability to treat all consumers with dignity and respect.
* Ensure consumers are cared for as required to minimise personal care issues that leave the consumers uncomfortable and humiliated.
* Seek consumer/representative feedback when personal care accidents occur and seek to improve their care based on the feedback.
* Review staff practices in high stress situations including behaviour management to ensure the appropriate the staff response is undertaken, and that staff are safe.

### Requirement 1(3)(b)

Care and services are culturally safe.

* Review consumer records and speak with consumers to ensure their care is culturally safe and reflective of what is culturally important to them.
* Work with lifestyle staff to ensure they are supported to provide individualised culturally appropriate meaningful cultural activities that are presented in a culturally safe manner.

### Requirement 1(3)(c)

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

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

* Continue to improve as advised in submission to the Commissioner.
* Ensure there is a robust process for care case conferences for every consumer to ensure that the consumer is making decisions about their care, preferences and needs and that these are translated into consistent practice.
* Review formal processes for case conferencing with representatives in relation to the use of restrictive practices.
* Ensure there is a robust process for capturing choices for all consumers and that these are enacted.
* Review and consider altering current visitor policy to allow for spontaneous visitors for consumers that wish this to occur.

### Requirement 1(3)(d)

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

* Continue to improve as advised in submission to the Commissioner.
* Ensure documents show that a risk assessment has been completed and discussed with the consumer/representative. It should also contain information about the actions taken to mitigate that risk. Where it is not possible for risks to be mitigated this should also be recorded and discussed and agreed with the consumer/representative.

### Requirement 2(3)(a)

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

* Review and ensure that assessment and planning processes are consistent and accurate for all consumers.
* Ensure that care planning is updated regularly to inform delivery of safe and effective care and services.

### Requirement 2(3)(b)

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

* Review and improve planning and assessment in relation to consumers current needs including wounds and post incidents.
* Ensure that all improvements are applied in practice consistently and accurately.
* Ensure that assessment and planning is improved as part of the Service’s continuous improvement plan as advised.

### Requirement 2(3)(c)

The organisation demonstrates that assessment and planning:

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

* Develop a clear robust process to partner with consumer’s in their ongoing care. This should also include others they wish to involve and other care and service providers.
* Ensure that all improvements are applied in practice consistently.
* Ensure there is adequate record keeping of all inputs into care planning for consumers whoever has been involved.

### Requirement 2(3)(d)

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

* Review and improve processes for informing consumers/representatives once a care plan has been updated.
* Review and improve processes for communicating and updating care plans after consumer care needs are updated by other care providers and organisations.
* Ensure once improvements are made these are implemented consistently for all consumers/representatives.

### Requirement 2(3)(e)

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

* Improve the review process for and deliver safe and effective clinical care when circumstances change or when incidents occur.
* Ensure that the review process is consistently used to effectively monitor and improve care and services for consumers.
* Ensure staff are consistently applying the expected level of reviews to care plans as outlined by the processes and procedures.
* Review, improve and deliver safe and effective personal care. This may involve looking at staffing levels as well as how the care is provided in practice.
* Review, improve and deliver safe and effective clinical care. This would include but is not limited to the areas of wound management, pain management, restrictive practices and behaviour/incident management.
* Review staff training to ensure that it is delivery information relating to best practice.
* Review and reduce the use of psychotropic medications in relation to restrictive practices and ensure staff are fully trained to understand their appropriate use.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(a)

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

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

* Review, improve and deliver safe and effective consumer care. This may involve looking at staffing levels as well as how the care is provided in practice.
* Review, improve and deliver safe and effective clinical care. This would include but is not limited to the areas of wound management, diabetes management, restrictive practices and behaviour/incident management.
* Review staff training to ensure that it is delivery information relating to best practice.
* Review and reduce the use of psychotropic medications in relation to restrictive practices and ensure staff are fully trained to understand their appropriate use.
* Actively seek representative feedback on consumer care and what improvements may be required including communication.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(b)

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

* Develop and implement a robust system for the effective management of high impact and high prevalence risk.
* Risks associated with behaviour and falls management should be addressed as a matter of priority.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(c)

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

* Review and seek consumer/representative feedback on processes relating to end of life so they can be improved and implemented.
* Review and seek learnings from consumers where they were their health was rapidly declining and their move to palliative care.
* Review processes for after-hours medical consults for deteriorating consumers.
* Ensure case conferences with representatives occur consistently during end of life care.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(d)

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

* Complete an in-depth review of the monitoring, responding, recording and communicating consumer deterioration.
* Review all processes in relation to recognition of consumer change in condition with focusing on identification and how this is communicated to ensure that care adjustments are made effectively and in a timely manner.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(e)

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

* Complete an in-depth review of the communication across the organisation in relation to consumer’s condition, needs and preferences. This should include seeking consumer/representative feedback to ensure consistently.
* Ensure that all documentation is improved in its timeliness.

### Requirement 3(3)(f)

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

* As a priority, review consumers requiring care from external care providers arrange referrals/appointments.
* Review referral processing times and look to make improvements so it is consistent especially in relation to behaviour management and consumer deterioration.

### Requirement 4(3)(a)

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

* Use consumer/representative feedback to make improvements to the lifestyle program.
* Review staffing levels in lifestyle area and ensure they are working well to provide lifestyle activities to consumers.
* Ensure all consumers are maximising their independence to the Service’s best ability – review access to indoors and outdoors and excursions.
* Re-evaluate and reinstate the services that were put on hold during COVID-19 so they meet consumers preferences.

### Requirement 4(3)(b)

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

* The Approved Provider needs to improve the daily living for each consumer in relation to psychological well-being, particularly in relation to change of consumer condition and when incidents occur.
* Seek feedback from consumers directly to ask how their emotional, spiritual and psychological well-being could be improved.
* Ensure that there is focused, individualised improvement to the daily living for each consumer in relation to emotional, spiritual and psychological well-being.

### Requirement 4(3)(c)

Services and supports for daily living assist each consumer to:

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

* Implement/re-establish community connections and lifestyle activities as stated in the Approved Provider response to the Commissioner.
* Review and improve lifestyle activities ensuring they are directly related to consumer interests and preferences.
* Look at new ways to provide daily support and services for consumers even when the service may be limited due to service illness or isolation. Seek lessons learnt and ideas of other aged care facilities to implement at the service to improve consumer outcomes.

### Requirement 4(3)(d)

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

* Develop and complete communication improvements as advised.
* Improve the documentation process (care plans) so that information is better able to be shared regarding consumer condition, needs and preferences.
* Build stronger working relationships with others involved in consumer care.

### Requirement 4(3)(f)

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

* Work with consumers and the new chef to rework and improve the menu.

### Requirement 5(3)(b)

*The service environment:*

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

* Ensure that consumer entry and exit points are clear, open and free from clutter so they feel free to move both indoors and outdoors when they wish.
* Conduct a risk assessment on the stairs located to the stairs for particularly for consumers living on the upper floor.

### Requirement 7(3)(a)

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

* Continue to look for ways to attract and retain qualified staff.
* Look at rostering to try to provide flexibility to the staffing so that shifts do not remain unfilled.
* Seek regular feedback from consumers/representatives to more readily know how staff shortages may be impacting the quality of consumer care.
* Complete improvements as advised in the response to the Commission.

### Requirement 7(3)(c)

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

* Identify knowledge gaps for staff to improve their competency in identified areas.
* Continue to review and develop a training plan based on the needs of the staff as identified.
* Continually identify knowledge gaps for staff to improve their competency in identified areas and seek their inputs.
* Seek regular personalised feedback for consumers and staff about agency staff performance.

### Requirement 7(3)(d)

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

* Review the care being provided to consumers with dementia and ensure that all staff working in this area are trained fully to care for these consumers.
* Ensure that staff knowledge transfers to improved practices.

### Requirement 8(3)(a)

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

* Seek feedback from consumers/representatives on how best to engage with them to allow them to have input into their care and services.
* Develop and implement ways to engage with consumers/representatives and ensure that these are
* Ensure all actions are documented including actions taken and also incorporated as part of continuous improvement.

### Requirement 8(3)(b)

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

* Continue to implement improvements to the governing body as discussed with the Assessment Team.
* Look for new ways to ensure the governing body is aware and actively seeking to promote a culture of safe, inclusive and quality care and services.
* Look for active ways for the governing body to be to accountable for their delivery of inclusive and culturally safe care and services and ensure these are evaluated and improved.

### Requirement 8(3)(c)

Effective organisation wide governance systems relating to the following:

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

* Ensure as a matter of importance that governance systems are developed and improved for information management, continuous improvement, regulatory compliance and workforce governance.
* The Approved Provider needs to implement governance improvements and solidify them into strong robust processes that translate to improved outcomes for consumers across the Service.

### Requirement 8(3)(d)

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

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

* The Approved Provider needs to investigate, research and implement improvements for risk management systems and practices.
* The Approved Provider should review incident protocols as soon as possible and implement and review improvements consistently and effectively.

### Requirement 8(3)(e)

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

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

* Research, develop and implement improvements to clinical governance framework with a focus on antimicrobial stewardship and use of restraint.
* Ensure that open disclosure is used consistently across the Service including ensuring staff are well trained and supported to ensure open disclosure is used.