Performance

Report

**1800 951 822**

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| Name of service: | Mark Moran at Little Bay |
| Service address: | 1420 Anzac Parade LITTLE BAY NSW 2036 |
| Commission ID: | 0804 |
| Approved provider: | Mark Moran at Little Bay Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 12 September 2022 to 14 September 2022 and 19 September 2022 to 21 September 2022 |
| Performance report date: | 3 November 2022 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Mark Moran at Little Bay (**the service**) has been prepared by Gill Jones, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 17 October 2022.

# Assessment summary

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

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

# Areas for improvement

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

Requirement 1(3)(f)

The Approved Provider must ensure each consumer’s right to privacy is respected, particularly when carrying out personal care, and consumer information is kept confidential.

Requirement 2(3)(b)

The Approved Provider must ensure the assessment and planning identifies and addresses the consumer’s current needs, goals and preferences and documentation is completed appropriately to guide the delivery of care.

Requirement 2(3)(d)

The Approved Provider must ensure the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is made readily available to the consumer.

Requirement 3(3)(a)

The Approved Provider must ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: is best practice; and is tailored to their needs; and optimises their health and well-being, particularly in relation to wound care and the use of psychotropic medication.

Requirement 3(3)(e)

The Approved Provider must ensure 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 5(3)(b)

The Approved Provider must ensure the service environment is safe, clean, well maintained and comfortable, particularly in relation to ensuring any environmental risk to consumer safety is identified and managed appropriately.

Requirement 7(3)(b)

The Approved Provider must ensure workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity.

Requirement 8(3)(b)

The Approved Provider must ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for its delivery by defining their strategic direction and performance measures and communicating these to stakeholders.

Requirement 8(3)(d)

The Approved Provider must ensure effective risk management systems and practices including oversight of all identified risks and timely review of risk controls, where needed, to minimise risk.

Requirement 8(3)(e)

The Approved Provider must ensure where clinical care is provided an effective clinical governance framework exists which includes effective clinical oversight of antimicrobial stewardship, minimising the use of restraint and open disclosure.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that Requirement 1(3)(f) is non-compliant.

The assessment team found most consumers and representatives advised that consumer privacy is being maintained and the team observed this. However, one consumer said their personal privacy is not being maintained and provided details about how this impacted their mental health. They said when staff take them out of the bathroom to get dressed in their room the room window blinds are often open and their room door is left ajar.

The Assessment Team also observed information privacy was compromised in areas across the service environment. The Assessment Team observed that most doors to the nurses’ stations and serveries were open or, if closed, were unlocked and in those areas was consumer personal information. This included, for example, meal plans for consumers, dietary preference forms about each consumer; doctors’ folders with details about consumers’ health/clinical conditions; a clinical handover sheet with care/clinical information about each consumer; and consumer information written on whiteboards. During the site audit the Approved Provider removed hard copy information from these areas.

The Approved Provider provided a response to the Assessment Team’s report.

The Approved Provider, in their response, stated that consumers with rooms on the ground floor have private courtyards and no-one can see through the window from outside meaning the consumer’s privacy was not compromised. They stated that this issue had previously been raised with consumers and reflected a ‘cognitive forgetfulness’ which should not have an impact on the service meeting this requirement. The Approved Provider stated they will continue to work with the consumer involved to ensure she has ‘minimum concerns’ about her privacy. The Approved Provider corrected information in the Assessment team’s report stating they had undertaken privacy training with staff prior to the site audit, not during the site audit, as documented.

Regarding the servery doors and nurse’s station doors being left open or unlocked, the Approved Provider stated that they identified this issue in April 2022 and intend to implement swipe access to these areas but works had been delayed due to outbreaks at the service. They stated that there have been no confidentiality breaches as far as consumers are concerned as visitors do not have access to the nurse’s desk and screens used are password protected and blank out after thirty seconds.

I have considered the information in the Assessment team’s report and the Approved Provider’s response. I note the Approved Provider has not responded to the issue of the consumer’s door being left ajar when care was being provided. Neither has the Approved Provider responded to the issue of consumer dietary information in hard copy being available to all in the servery.

I am not persuaded by the Approved Provider’s response. The Approved Provider disputes that the consumer’s privacy was compromised as ‘no-one can see through the window’ but clearly the consumer involved has concerns and staff need to respect that when caring out personal care. Equally, whilst I recognise that the Approved Provider has taken steps to introduce swipe doors on the nurse’s station and the servery, at the time of the audit, consumer’s personal information was accessible to anyone entering both the nurse’s stations and the serveries.

Overall, it has not been demonstrated that consumer privacy is respected or that their personal information has been kept confidential, noting the latter has been a long-standing issue and was not resolved as planned or addressed through other temporary measures.

I am satisfied that the five remaining Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d) and 1(3)(e) are compliant.

Consumers and representatives said staff respect their culture, and staff provide care and services which are safe. Consumers and representatives said they feel supported by the service to exercise choice and independence and to be involved in making decisions about the care they receive and how it is delivered. Consumers interviewed said that staff ask them about their preferences and they can choose how they wish to spend their day and feel encouraged to join in activities if they choose to do so. Consumers and representatives said they feel consumers are able to maintain relationships of choice and they feel welcome when they visit or have visitors at the service. Consumers and representatives shared stories that show the service supports consumers, and risk taking is encouraged and supported to facilitate the consumers to live the best life they can. Consumers and representatives stated that information is being provided which helps them make day to day choices.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

I have assessed this Quality Standards as non-compliant as I am satisfied Requirement 2(3)(b) and Requirement 2(3)(d) are non-compliant.

With regard to assessment and planning identifying and addressing the consumer’s current needs, the Assessment Team identified several consumers where their current care needs were not adequately identified in their care planning documentation. This included two consumers whose current care needs associated with their diabetes management were not adequately identified in their care planning documentation. For one consumer instructions in her diabetes management plan lacked specificity about blood sugar monitoring (BSL) and insulin therapy. For the other consumer, care planning documentation did not reflect her need for supper at 8pm or her need for her insulin to be delayed for any reason. The Assessment team also found care planning documentation for two consumers did not reflect the consumer’s current needs with regard to wound management. For one consumer there was no evidence of a wound care plan for a chronic wound and for the other consumer a wound care plan for a skin tear was not evidenced. Lastly, the Assessment team identified three consumers on long term prophylactic antimicrobial therapy however this information was not recorded in their care plans and there was a lack of evidence of review of this treatment or oversight of it by the Medication Advisory Committee (MAC).

The Assessment Team found that whilst the outcomes of assessment and planning are communicated to the consumer and others that the consumer wishes to involve, feedback from consumers and their representatives indicates the care and services plan is not readily available to them. The Assessment Team found only six out of the 23 consumers and representatives interviewed had been offered a copy of the care plan.

The Approved Provider provided a response to the Assessment Team’s report.

The Approved Provider responded with information previously provided to the Assessment team about how consumers are informed through the consumer handbook about their ability to request a copy of their care plan and evidence showing a family member had been provided a copy of the care plan on 22 June 2022. I am not persuaded by the response by the Approved Provider that processes for providing consumers and representatives with a copy of the care plan are sufficiently well implemented into everyday practice. I note that Approved Provider has taken action, since the site audit, to formalise a system of offering consumers and representatives a copy of their care plan.

With regard to assessment and planning identifying and addressing the consumer’s current needs, the Approved Provider provided the Diabetes Care Plan for one of the consumer’s cited in the team’s report which contained information about BGL monitoring and insulin therapy. The Approved Provider also supplied evidence of GP monitoring of this consumer’s diabetes management on 28 June 2022. I find there are discrepancies in the consumer’s diabetes management plan. The plan records that BSL’s are due both twice daily and three times daily. That said, staff are doing BGL readings three times per day. The consumer’s insulin is being given as required and there is evidence of GP review and the consumer’s condition is stable.

For the second consumer with diabetes, the Approved Provider provided the BGL monitoring chart and her hospital discharge summary just prior to entering the service. The discharge summary corrected information in the Assessment Team’s report by demonstrating that the consumer had commenced on insulin in hospital prior to entering the service as her diabetes had been managed poorly at home. The BGL chart shows BGLs are taken twice daily and there are four instances where the RN has made a decision to delay the consumer’s insulin till after breakfast as BGL reading between 5.2 and 5.4 mmols/L prior to breakfast. I find that flexibility with the timing of the consumer’s insulin is not noted in their care plan and insulin was delayed on four occasions between 28 August and 10 September 2022 when BSL’s were between 5.2mmol/L and 5.4mmol/L, which were at the lower end of her normal range, without notifying the doctor. I am satisfied, however, that the RN made a professional decision to delay the insulin as the consumer’s BGL was only just above the acceptable range for her to be given insulin. I am also satisfied that the GP was not notified on these occasions as the consumer’s BSL was within her normal range. That said, whilst the decision to delay the insulin is clearly documented in the BGL monitoring chart for review by the GP, I am of the view that this matter should have been discussed within the nursing team and with the GP at a subsequent review and to ensure a consistent approach to the management the consumer’s insulin. The BGL chart supplied demonstrates that, on each of the four occasions the consumer’s BGL was repeated later in the morning prior to the administration of insulin. I am therefore confident that the consumer’s diabetes was being adequately managed but find there is a lack of a multidisciplinary approach to assessment and planning in the ongoing delivery of her care.

With regards to wound management and the absence of wound care documentation for one consumer with a chronic wound, the Approved Provider stated that the consumer has a wound chart with management plan which contains the interventions necessary to manage her skin integrity and treat the wound to her right foot. This documentation was not supplied but the Approved Provider supplied photographic evidence showing that the wound was almost healed. Based on information provided, I am satisfied, that this consumer’s skin integrity and wound management is being assessed and planned but I am not clear what documentation is being completed.

With regard to the second consumer with a skin tear without any wound charting completed, the Approved Provider acknowledged that the RN involved had not followed procedures. They provided documentation showing a performance discussion held with the RN on 14 September 2022, during the site audit.

Regarding long term prophylactic antimicrobial therapy not documented in care plans, the Approved Provider stated it is not their practice to document these medications in medication care plans as recorded on the consumer’s medication chart. The Approved Provider stated that the continued use of this therapy is reviewed by the GP at least four monthly when routine medication reviews are performed. I am satisfied, based on the information provided by the Approved Provider, that this long term prophylactic antimicrobial therapy is being assessed and managed for these consumers by the GP.

Lastly, the Assessment team identified another consumer who developed a Stage 1 pressure injury that was not photographed or documented when found just prior to the consumer being sent to hospital on 28 August 2022. She returned with two additional pressure injuries which were inadequately documented and wound care charts not completed for up to 12 days after transfer from hospital on 7 September 2022. The Approved Provider acknowledged this had been an error and they have now implemented a head to toe assessment post hospital transfer.

I am therefore not persuaded by information provided by the Approved Provider that assessment and care planning identifies and addresses the consumer’s current needs, goals and preferences.

I am satisfied that the three remaining Requirements 2(3)(a), 2(3)(c) and 2(3)(e) are compliant.

The Assessment Team found consumers and representatives said they were involved in and were asked a lot of questions regarding the consumer’s care needs on entry to the service. Risks are generally assessed, and this includes but is not limited to allergies, falls, dietary restrictions and skin integrity.

The Assessment Team also identified that, whilst the service has a process of care conferences and they meet with consumers and their representatives regularly to discuss the consumers’ care needs, the effectiveness of this process in consistently establishing ongoing partnerships in care and services is not clear based on the feedback from seven out of twenty-three consumers/their representatives interviewed.

The service was able to demonstrate that care and services are monitored and reviewed for effectiveness, including when incidents or changes occur. Care documents reviewed show care and services are being reviewed, the registered nurse (RN) uses a resident of the day process to regularly review consumers and their care. Care plans reviewed show they are generally updated and changed when incidents occur or circumstances change.

With regards to assessment and planning being based is based on ongoing partnership with consumers and their representatives, the Approved Provider responded with information showing the variety of ways consumers and their representatives are involved and pointed to information in the Assessment Teams report stating consumers and their representative feel involved in the consumer’s assessment and care planning. For one of the consumer representative who did not feel sufficiently involved the Approved Provider stated that they had been involved in six case conferences since 2018 and have been included in communications following ‘Resident of the Day’ assessments. I am persuaded by the evidence contained both in the Assessment Team’s report and the response by the Approved Provider that consumers and their representatives are sufficiently involved as partners in care.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I have assessed this Quality Standards as non-compliant as I am satisfied Requirement 3(3)(a) and Requirement 3(3)(e) are non-compliant.

The Assessment team found that whilst consumers and representatives interviewed provided positive feedback about care delivery the service was unable to demonstrate that each consumer receives safe and effective care that is best practice, tailored to their needs and optimises their health and well-being in relation to bowel management, wound care management, pain management, diabetes management and medication management.

The Assessment Team identified gaps in the bowel management and pressure injury management for one consumer. With regard to bowel management the Assessment Team found that her bowel management was not individualised, monitored and interventions to manage were not best practice due, in part, by a reliance on the use of suppositories rather than other less invasive methods. As discussed in Requirement 2(3)(b) this consumer had a chronic wound and the Assessment team could not locate a wound management plan for this wound, neither was there a referral to a wound specialist or regular review by the GP. Furthermore, the Assessment team identified another consumer who developed a Stage 1 pressure injury that was not photographed or documented when found just prior to her being sent to hospital on 28 August 2022. She returned with two additional pressure injuries which were inadequately documented, and wound care charts not completed for up to 12 days after transfer from hospital on 7 September 2022.

As discussed in Requirement 2(3)(b), the Assessment Team identified another consumer whom had not had a wound care plan commenced for a skin tear and documentation does not show ongoing review of her pain management regime. The consumer’s pain management directive completed by the physiotherapist documented massage to lower back and hip by RN weekly but this had not been attended to since November 2021. The Assessment team also identified another consumer who said she was experiencing pain in her right shoulder and had missed her four times weekly massages by the Physiotherapist.

Lastly, the Assessment team identified a consumer on four psychotropic medications whose Residential Medication Management Review on 9 May 2022 identified the possibility of multiple side effects from the number of medications being taken. The last entry in the consumer’s behaviour management chart was 1 January 2022.

The Approved Provider provided a response to the Assessment Team’s report.

The Approved Provider, in their response to the management of one consumer’s bowels, supplied the consumer’s Bowel Care Plan, Dietary Care Plan and Dietary form. The Dietary Care plan and Dietary form includes use of prunes and Resource 2.0 Fibre supplement to address ongoing constipation. The Approved Provider stated, but did not supply evidence of, GP review of the consumer’s bowels on 16 Sept 2022. The Approved Provider stated that the GP indicated there were no other alternative dietary options available to explore, due to the consumer’s other conditions, to avoid the use of suppositories, when required. During this review it is noted that the GP added enemata, as required, as another strategy in managing this consumer’s ongoing constipation. The Approved Provider stated they have a system for identifying when consumers have not had their bowels open for three days and this triggers interventions by the Registered Nurse. With regard to this consumer’s pressure injury the Approved Provider stated that the consumer has a wound chart with management plan which contains the interventions necessary, including third daily dressings, to treat the chronic wound to her right foot. This document was not supplied but the Approved Provider supplied photographic evidence showing that the wound was almost healed. The Approved Provider provided evidence of GP review of this wound on 10 September 2022 which they stated was supplied to the Assessment Team during the site audit. The GP noted the wound is continuing to heal and to continue the current regime.

Likewise, with regard to the consumer the Assessment team identified with a skin tear and no wound charting the Approved Provider acknowledged that this was an error and the RN had been performance managed. With regard to this consumer’s pain management directive and whether the consumer’s pain had been reviewed regularly the Approved Provider provided evidence of regular review by the RN from 23 January 22 to 23 September 2022.

Regarding the consumer who said she was experiencing pain in her right shoulder and stated she had missed her four times weekly massages by the Physiotherapist – the Approved Provider provided care documentation showing that the consumer was receiving heat pack therapy, walking therapy and massage to her lower back (not right shoulder) by the Occupational Therapist for 80 mins per week, spread over 3-4 sessions. This care was documented as completed except for when the consumer was isolating due to COVID. The Approved Provider also submitted documentation showing the consumer had been reviewed by her GP on 15 August 2022 and pain in right shoulder was not recorded as an issue.

With regard to the consumer with three significant pressure injuries, two of which were not documented for a significant period after return to the service, the Approved Provider acknowledged this had been an error and they have now implemented a head to toe assessment post hospital transfer.

Lastly with regard to the consumer taking four medications the Approved Provider submitted a risk care plan which they stated was archived on 28 August 2022. There is no explanation from the Approved Provider why this plan was archived although during the site audit the Approved Provider stated that the psychotropic medication being given was no longer considered chemical restraint. The risk care plan, now archived, shows that the consumer was prescribed psychotropic medication as a chemical restraint for the management of agitation and refusal of personal care. The risk care plan records the need for staff to monitor side effects of the medication and inform GP, with three monthly medication review by GP and next of kin. The Approved Provider argued that the GP was monitoring the consumer’s medication three monthly when re-prescribing however, the Approved Provider’s response does not demonstrate how care staff are monitoring the consumer’s behaviour or what side effects staff are to watch for. The Approved Provider stated, in response to a finding by the Assessment Team that there was confusion about the use of psychotropic medication for this particular consumer and whether this was chemical restraint, that there was no such confusion as it was very clearly documented on the consumer’s medication chart and consent form that the medication was for management of their chronic medical condition and, was therefore, not chemical restraint.

I am not persuaded by the response of the Approved Provider that this requirement is compliant. The lack of effective clinical care provided to one consumer for the management of multiple pressure injuries and the significant gaps identified in wound care documentation for several consumers plus the absence of behaviour monitoring for a consumer taking multiple psychotropic medications does not demonstrate consumers are receiving safe and effective care that is best practice, tailored to their needs and optimises their health and well-being.

The Assessment team found that communication about consumer’s condition, needs, and preferences is not communicated in a timely manner within the organisation and with others where responsibility is shared. The Assessment team received feedback from one representative that information they provided was not satisfactorily shared amongst the nursing team. Another representative spoke about a complaint made in which they were not notified that their mother had been admitted to hospital until some seven hours later. They were also dissatisfied about the level of information provided about the fall that led to the hospital admission. The Assessment team also identified consumer’s dietary needs were not being communicated to the kitchen. Additionally, a representative spoke of the time taken for the GP to write up changed medication after the specialist had made a change.

The Approved Providers response included information about the delay in notifying a representative about the consumer’s admission to hospital. They acknowledged the delay and how they had addressed this issue with the RN involved. With regard to the delay in the GP writing up changed medication when the specialist had made a change, the Approved Provider stated that this normally took up to 5 days as the GP waited to receive written information from the specialist prior to changing the medication order. In relation to dietary needs not communicated to the kitchen, the Approved Provider provided evidence that, for one consumer, the kitchen was aware the consumer required a diabetic diet.

I accept the Approved Provider’s argument that the GP wishes to see the specialists instructions in writing before changing medication and it can take up to five days for this information to be received. Additionally, information received from the Approved Provider demonstrates that the kitchen were aware of at least one of the consumer’s dietary needs but I am not persuaded by the Approved Provider’s response that this requirement is complaint.

In finding this requirement non-compliant I have considered the delay in notifying a consumer’s representative about her mother’s admission to hospital and the perceived lack of information provided to them about the incident that led to the hospital admission. I have also considered the gaps identified in Requirement 2(3)(b), 2(3)(e) and 3(3)(a) as evidence that information about consumer’s needs, preferences and needs is not appropriately documented and shared within the organisation and with others where responsibility for care is shared.

I am satisfied that the five remaining Requirements 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(f) and 3(3)(g) are compliant.

With regard to high impact high prevalence risks the Assessment team found falls were being well managed. The Assessment team raised a concern about the gaps between medication rounds in terms of whether medication, in this case paracetamol, prescribed four hourly was actually being given four hourly as prescribed. Lastly, the Assessment team brought forward issues about the management of insulin for two consumers. The Approved Provider responded to the medication issue stating that network issues prevented RN’s always recording the actual times medication was given. Network issues obviously require attention but this did not seem to be having an adverse effect on consumer’s pain management. Additionally, I have reviewed the care provided to the two consumers being administered insulin and find that the risk associated with managing their diabetes has been effectively managed.

The service was able to demonstrate a process for recognising and addressing the needs, goals and preferences of consumers nearing the end of life. For the consumer sampled, their care and service records reflect that their comfort was maximised and their dignity preserved when receiving end of life care.

The service demonstrates that deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. For the consumers sampled, their care planning documents and progress notes reflect the identification of and response to deterioration or changes in their health condition.

For most of the consumers sampled, care planning documents show referral to allied health, medical specialists and others and consumers provided predominantly positive feedback about the referral process.

The service has processes in place for infection prevention and control through implementation of standard and transmission based precautions and demonstrated practices to minimise infection related risks for some consumers sampled.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

I have assessed this Quality Standards as compliant as I am satisfied that Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g) are compliant.

With regards to Requirement 4(3)(g) the Assessment Team found that, whilst the majority of consumers/representatives interviewed stated consumers enjoy the meals, get enough to eat and there is a varied menu, a small number of consumers or their representatives’ raised issues about food being repetitive and not looking appetizing (particularly the puree food), and the absence of fresh fruit. The Assessment team noted that, although the service had taken up some suggestions made by the dietician not all had been followed. The Assessment team also found some items in fridges and cupboards that had not been labelled with a use by date.

The Approved Provider provided a response to the Assessment Team’s report.

Having reviewed this response I am satisfied that fresh fruit is readily available, consumers can request a different meal if they want to, and staff are being reminded to label food in fridges. The Approved Provider provided pictures of puree food served and I note significant effort is made to make all food look appetizing. The Approved Provider stated that all dieticians recommendations are taken on board and consumers are regularly engaged in providing feedback on the menu.

While some consumers and representatives had minor concerns regarding laundry services, overall consumers and representatives sampled were satisfied with the services and support for daily living to meet the consumer’s needs, goals and preferences. Staff interviewed were able to describe consumer’s interests with documentation supporting consumers’ goals and optimising their health and well-being for daily living. Consumer’s care and services records reviewed include information about their life, hobbies, cultural and spiritual preferences.

Consumers and representatives provided positive feedback about services and supports for consumer emotional, spiritual and psychological well-being. Staff interviewed were able to describe how they notice when a consumer is feeling low by recognising changes in their mood and behaviours and said they provide extra time and one on one emotional support to the consumer. Care and service records for all sampled consumers reflect their faith, beliefs and spiritual preferences.

The service was able to demonstrate consumers have been provided with services and supports for daily living to assist them to participate in their community within and outside the organisation’s environment, maintain their social and personal relationships and do things of interest to them.

Care and service records sampled show consumers’ needs and preferences are included to inform the delivery of services and supports for daily living and to enable them to do things of interest to them. Clinical and care staff described what is important to the consumers whom they look after, and this was consistent with information in consumer care plans.

The service demonstrated timely and appropriate referrals of consumers to other organisations, individuals and providers of other care and services as this relates to consumer daily living. Consumers’ care planning documentation shows the service collaborates with external providers to support the needs of consumers.

Consumers and representatives did not raise concerns about equipment relating to services and supports for daily living. Staff across departments such as catering, cleaning, maintenance and lifestyle provided information about having the equipment and supplies needed to deliver the services and supports required by the Quality Standards.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that Requirement 5(3)(b) is non-compliant.

Consumers and representatives provided information about the service environment being safe, well maintained and comfortable, and about the consumer being able to move freely. Most provided feedback about satisfaction with cleanliness, but four consumer representatives stated that cleanliness could be improved. The Assessment Team identified a number of utility rooms and serveries that were not clean, doors not closing properly, courtyards with rubbish on the ground and paving stone/s lifting, and extensive cobwebbing to the outside of the building in both common areas and consumer rooms. Additionally, the Assessment team identified some risk to consumer’s safety, health and well-being from servery doors being open, smoking areas without fire suppression equipment and evacuation plans not being clear.

The Approved Provider provided a response to the Assessment Team’s report.

The Approved Provider stated that locking the servery doors was already in their improvement plan but had not been enacted due to the number of outbreaks in the service this year preventing work to be completed. It was projected this would be completed by 28 October 2022. The issue with the paver in the garden was fixed 23 September 2022 and pictures supplied to show this. Pictures showing fire extinguishers and fire blankets in place were also included in the Approved Provider’s response. The Approved Provider provided evidence that way finder signage had been installed on 10 October 2022 to assist with fire evacuation. The issue of door locks not working was addressed when the Assessment Team was on site.

Whilst the Approved Provider stated no incidents had been recorded associated with the safety of consumers from the open serveries and lack of fire suppression equipment nearby in the smoking areas I find that the risk to the health, safety and well-being to consumers had not been properly considered. Additionally, cleanliness issues, doors not closing, lifting paving slab/s, and fire evacuation plans which were not clear had not been identified by the Approved Provider’s own auditing systems prior to the Assessment Team’s visit. I note that the Approved Provider stated that prior to the site audit they had decided to increase their environmental audits to twice yearly to enhance their monitoring.

I am satisfied that the two remaining Requirements 5(3)(a), and 5(3)(c) are compliant.

Consumers and representatives provided information indicating they think the service is welcoming and easy to understand for the consumer and that the consumer is able to move around the service environment with ease. The Assessment Team’s observations confirmed this in the main, noting that some aspects of the service environment have not been optimised for consumers living with dementia. The service management team provided the results of an audit against the dementia enabling design principles undertaken during the site audit. This showed overall satisfactory performance with some areas for improvement. The Assessment Team did not identify any adverse impact on current consumers.

Consumers and representatives did not have any concerns in relation to furniture, fittings and equipment or they provided positive feedback.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

I have assessed this Quality Standard as compliant as I am satisfied that Requirements 6(3)(a), 6(3)(b), 6(3)(c), and 6(3)(d) are compliant.

Consumers and representatives shared that they feel comfortable giving feedback and would feel comfortable complaining. Most of those who had complained felt listened to and thought their concerns were welcomed. While there was some negative feedback from 2 consumers and a representative, overall, it was demonstrated that consumers are being encouraged and supported to give feedback and make complaints.

Consumers and representatives shared that they have been provided with information about advocacy and language services to raise or resolve complaints or said they knew how to obtain this information, if needed.

The Assessment Team sampled consumers/representatives who have made a complaint to the service in 2022, based on the service’s complaints register and related records. Consumers and representatives provided mixed feedback about their satisfaction with the resolution of their complaint however the service management team demonstrated complaints are actioned and open disclosure is used, and complaint records reviewed show this.

Consumers and representatives in the main reported that when they have given feedback or made a complaint their input or concerns have been used to bring about improvement, however there were some exceptions as noted under Requirement (3)(c).

# Standard 7

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that Requirement 7(3)(b) is non-compliant.

The Assessment team found most consumers and representatives thought the staff were kind, caring and respectful towards them/their relative however two consumers said staff could be either ‘cranky’ when they used their call bell or threaten not to attend to them during the night if they used their call bell. This consumer said this made them anxious. Furthermore, a representative said they had seen staff member hit a consumer on the arm and said their manner was abrupt.

The Approved Provider provided a response to the Assessment Team’s report.

The Approved Provider argued that one of the consumers the Assessment Team spoke with has severe anxiety, depression and mild cognitive impairment and focusses on negative things. The Approved Provider thought the Assessment team should have considered this in accepting the consumer’s feedback. The Approved Provider noted the second consumer providing negative feedback wished to remain anonymous and the consumer representative who alleged physical abuse witnessed refused to provide them with any further information.

I am not persuaded by the response of the Approved Provider that this requirement is compliant. I find the Approved Provider’s response lacks compassion as their response fails to demonstrate they have considered the impact of staff actions and behaviour on the consumers involved and other who witnessed it.

I am satisfied that the four remaining Requirements 7(3)(a), 7(3)(c), 7(3)(d), and 7(3)(e) are compliant.

With regard to staffing, the Assessment team identified that, whilst there is there is workforce planning the workforce deployed is not enabling the delivery and management of safe and quality care and services. Some consumers, their representative and staff provided this feedback and it is recorded in some management/staff meeting minutes. Additionally, call bell/sensor alert response time reports show longer than ten minute waits for call bells to be answered on occasion. The Assessment team found the service does not have a routine system for ongoing monitoring of call bell/sensor alert responses by staff to enable related review of workforce adequacy, rather this is done on an adhoc basis. While there is a plan to improve monitoring, this had not yet been implemented and so was unable to be demonstrated during the site audit. The Assessment team found some adverse impact on consumer health and well-being.

The Approved provider stated that adverse consumer feedback about staffing had been received in June 2022 at a Residents meeting and nothing since. Only two agency staff had been used and all rostered shifts filled during the period studied by the Assessment team. The Approved Provider sated the service is running with higher than the recommended number of 200 care hours per each resident. The Approved Provider also stated that last year they increased the amount of buddy shifts to enable new staff to be well orientated and this has been most successful. The Provider responded to the issue of monitoring call bell responses stating this is done randomly on a weekly basis as per information given to the Assessment team.

Whilst I acknowledge the findings of the Assessment team I find that there is little evidence that consumer’s health and wellbeing has been impacted by the lack of workforce deployed to provide safe quality care and service. I am therefore persuaded by the information before me 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.

The Assessment team found most consumers and representatives think staff know what they are doing but three raised concerns about new staff not always know what to do. Interviews with management and staff and the review of relevant documentation shows staff have the necessary qualifications and necessary competencies determined by their role. However, the Assessment Team found competency is not being assessed on an ongoing basis, some staff interviewed lack knowledge relevant to their role and the practices of some staff show they lack knowledge or skills relevant to their role. The service management team is aware of the need to further support the newly registered RNs to perform their role effectively and has taken steps to provide the support.

The Approved Provider provided information which they stated was made available to the Assessment team during the site audit which shows all staff have undertaken the necessary mandatory training and competencies. The information provided did indeed show training provided to all staff currently working in the service. The Approved Provider stated that they have recently increased the number of buddy shifts to help new staff settle in and the new RN’s are being supported by management. On balance, I am persuaded by the Approved Provider’s response that the workforce are competent and have the necessary qualifications and knowledge to do their job.

The service has a staff recruitment and orientation processes and a program of staff mandatory training. Review of a sample of staff personnel files and additional records provided showed that staff recruitment and orientation processes are being followed and mandatory training undertaken in the last 12 months.

All staff interviewed about performance assessment and monitoring advised they had participated in a performance appraisal in the last 12 months and it happens on an ongoing basis.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

I have assessed this Quality Standard is non-compliant as Requirement 8(3)(b), 8(3)(d) and 8(3)(e) are non-compliant.

The Assessment team found that, while there are plans for the governing body to promote a culture of safe, inclusive and quality care and to be accountable for their delivery, there are significant gaps. The board’s expectations regarding inclusivity are not clearly set out and inclusivity is not well promoted. While commitments have been made in framework documents and policies most of the information about outcomes for consumers and service performance against the Quality Standards is not being systematically reported to the governing body so they can effectively direct and control the organisation. The strategic plan 2021/22 included goals, some without a stated intention and the draft strategic plan 2022/23 sets out areas of activity and a description of them. Neither strategic plan includes key elements of a strategic plan, such as analysis of the context, long-term goals, or action plans. Neither strategic plan includes a full set of key performance indicators or measures. The CEO informed the Assessment Team that strategic objectives are known and performance against them is monitored in informal ways. The Assessment Team identified the terms of reference for board meetings do not set out standing agenda items or include anything specific about reports to be tabled other than ‘Oversee quality and safety indicators to ensure that the Executive are meeting or exceeding benchmarks and otherwise reaching suitable quality outcomes’. It was not demonstrated that performance indicators and related benchmarks (or other performance measures) have been defined/determined and expectations communicated by the board to the executive management team. Review of recent monthly reports to the Board show regular reporting on national mandatory quality indicator (NMQI) performance and results from internal quality audits per month, with some analysis and commentary. They show some reporting on other outcomes for consumers, such as complaints and SIRS notifications although not systematically or consistently. They include, at times, limited information about what has been done or is being done to address trends, resolve complaints or mitigate related risks. They do not show trends over time. Minutes of recent EMT meetings show minimal information about outcomes for consumers or monitoring of service performance against the Quality Standards (other than as assessed externally by the Commission on occasion). The minutes do not include any reference to reports tabled or consistent discussion about, for example, adverse and sentinel events, number and weight of medium/high risks on the risk register, or strategic continuous improvement plans and progress as specified in policy.

The Assessment team found effective risk management systems and practices have not been demonstrated overall or in relation to managing high impact and high prevalence risks associated with the care of consumers and managing and preventing consumer incidents. The Assessment Team did not identify any major gaps in the identification and response to consumer abuse and neglect or in supporting consumers to live the best life they can, although there is an area for improvement in relation to oversight of serious incidents. The Assessment Team found that whilst the organisation has a risk management framework it does not specify risk appetite or tolerances. Whilst the organisation has a risk register Board meeting minutes/extracts do not show the risk register has been tabled resulting in the organisation not being able to demonstrate effective oversight of all identified risks and timely review of risk controls, where needed. There are general risk registers (organisational and local) with strategic and operational risks and a local consumer specific risk register which show how some risks have been identified, assessed, risk rated (using a specified risk matrix and traffic light system) and risk controls developed. Despite these documents listed above a fully formed risk management framework or strategy tailored to the organisation was not demonstrated.

In relation to clinical governance the Assessment team found an effective clinical governance framework has not been demonstrated. The organisation’s clinical governance framework, dated 13 September 2021, does not reflect the pillars of clinical governance rather sets out systems and processes for complying with Quality Standards 2 and 3 for day to day consumer assessment, care planning and care delivery. It does not, for example, set out the governance and leadership role of the governing body; the clinical safety and quality improvement systems; or how clinical performance and effectiveness will be monitored and reviewed. The governance-clinical policy does include this information, however it has not been demonstrated it informs practice. It includes, for example, that clinical performance and effectiveness will be monitored through consumer feedback and experience, quality and clinical indicators and incident rates. As noted under Standard 8, Requirement (3)(b) not all of this information is being systematically reported to the board. The Assessment team identified gaps in practice in relation to antimicrobial stewardship (AMS). Antimicrobial drug usage reports show around 50% of antimicrobials were prescribed prior to pathology to confirm the presence of infection and the pathogen. The organisation’s corporate governance framework includes that antibiotic use outcomes will be monitored but there is a lack of evidence that the organisation’s commitment and processes to support AMS are being promoted to prescribers to bring about improvements or any related plans. The Assessment Team did not identify any major gaps in minimising the use of restraint or open disclosure, although there is an area for improvement in relation to oversight of chemical restraint.

The Approved Provider provided a response to the Assessment Team’s report.

The Approved Provider provided significant amounts of detail about their achievements in the area of cultural diversity and how inclusiveness drives their day to day practices. They also responded to the Assessment team’s findings that the executive management team are not receiving information they need to make judgements about outcomes for consumers and how the service is performing against the Quality Standards. The Approved Provider confirmed information in the Assessment team’s report stated that the findings from their schedule of audits on the Quality Standards is reported to the Board every month for every facility in the group. In addition, a high impact high prevalence events report has recently been approved for Board use to ensure Board oversight. Additionally, Board members visit the service most week days and Resident and Representative meeting minutes are made available to the Board. The Approved Provider’s response provided no further information about how the organisation sets its strategic direction and how the Board demonstrates their accountability for the provision of quality care through monitoring the performance of the organisation.

The Approved Provider responded that they have systems that foster effective risk management practices through their suite of assessments through their electronic clinical software programme, their incident management system, continuous improvement and risk assessment processes. As part of this process the organisation identifies and evaluates incidents, near misses and risks to the consumer and they practice open disclosure when things go wrong. They pointed to their management of psychotropic medications as an examples of managing high risk medications and their record in responding to elder abuse and the neglect of consumers. The Approved provider did not respond to information in the Assessment teams report about the deficits in their risk management framework and risk register and how the risk register has not been tabled to the Board resulting in the organisation not being able to demonstrate effective oversight of all identified risks and timely review of risk controls, where needed.

With regard to clinical governance the Approved Provider stated that three Board members review daily the clinical and shift handover reports and they take the lead in being across all clinical issues as Board members. The Approved Provider stated they have a Clinical Quality Risk Committee that meets monthly to review all clinical areas of risk, identify trends, recommend actions which is reflected in meeting minutes and the continuous improvement plan. The Approved Provider stated both of these documents were provided to the Assessment team whilst on site. The Approved Provider stated that high risk information or adverse events are reported the Board monthly. The Approved Provider did not respond to the Assessment Team’s findings that the organisation’s clinical governance framework does not reflect the pillars of clinical governance or set out the governance and leadership role of the governing body; the clinical safety and quality improvement systems; or how clinical performance and effectiveness will be monitored and reviewed. The governance-clinical policy states that clinical performance and effectiveness will be monitored through consumer feedback and experience, quality and clinical indicators and incident rates however, as noted in Requirement (3)(b) not all of this information is being systematically reported to the board. I have noted the service has policies and procedures in relation to antimicrobial stewardship, restrictive practices and open disclosure. Regarding the use of anti-microbials, the Approved Provider stated that prophylactic use of antibiotics is not included in the infection register as it is a preventative measure, not an active treatment of an acute infection. This is an area for improvement for the provider to monitor the use of prophylactic antimicrobial more closely. The Approved Provider did not respond to the issues identified by the Assessment team in relation to AMS or provide any further information regarding how it is managing AMS within its clinical governance framework.

Whilst I note that the organisation has a policies and procedures to support AMS, open disclosure and minimising the use of restraint I am not persuaded by the response by the Approved Provider that this requirement is compliant as the organisation does not demonstrate effective clinical governance and clinical oversight to ensure effective and safe quality care and services.

I am satisfied that Requirements 8(3)(a), and 8(3)(c) are compliant.

The organisation’s corporate governance framework has a section about consumer engagement, which includes a statement of commitment and basic information about engaging consumers such as through resident meetings and feedback mechanisms. It does not include information about the governing’s body’s role or connection to consumer engagement but overall, it has been demonstrated that consumer engagement is occurring.

Effective organisation wide governance systems were demonstrated in the main in relation to information management, continuous improvement, financial governance, workforce governance, and feedback and complaints. There is an area for improvement in relation to regulatory compliance regarding behaviour support plans, but other recent regulatory changes have been identified and met. There is an area for improvement in relation to governing body oversight of continuous improvement and complaints.

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