Performance

Report

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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 Mater Christi Aged Care Facility (**the service**) has been considered by Gill Jones, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 19 July 2022.

**Assessment summary**

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

* Ensure assessment and care planning processes include risks to the consumer’s health and well-being, particularly with regard to the use of restrictive practices, anti-coagulant therapy and falls.
* Ensure assessment and care planning processes identify and address the consumer’s needs, goals and preferences, particularly with regard to falls prevention.
* Ensure care and services are reviewed regularly for effectiveness when circumstances change or when incidents impact on the needs, goals or preferences of the consumer, particularly with regard to changed behaviour and falls management.
* Ensure clinical and personal care provided is best practice, tailored to needs and optimises consumer’s health and well-being, particularly in relation to pain management, wound care including wound care documentation.
* Ensure effective risk management of high impact, high prevalence risks associated with the care of consumers
* Ensure each consumer gets safe and effective services and supports for daily living that meets the consumer’s needs, goals, and preferences, particularly in relation to lifestyle and activities.
* Ensure effective risk management systems and practices, particularly in relation to managing high impact, high prevalence risks and incidents.

# Standard 1

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

## Findings

Overall sampled consumers considered they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose.

For example:

* Consumers and representatives said staff treat consumers respectfully and expressed satisfaction with the interaction and engagement with staff across all aspects of care and services.
* Consumers and representatives interviewed confirmed that consumers are encouraged to do things for themselves and that staff know what is important to them. Consumers provided examples of matters of importance to them, acknowledged staff awareness and staff response to support their choices, preferences and decisions.
* Interviews with staff and review of care documents demonstrated relevant information is collected and shared to support consumers’ choice and their decisions are respected and shared with relevant care and service staff.
* Consumers’ relationships are acknowledged and supported; consultation occurs to ensure staff awareness of matters of importance to the consumer to support the consumer to live the best life they can.

# Standard 2

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

# Findings

Overall sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services.

For example:

* Sampled consumers and representatives gave positive feedback regarding the wonderful care and attention consumers receive. They said staff are kind and polite towards consumers and visitors.
* Consumers and representative interviewed said the advance care plan is discussed when the consumer first enters the service and if the consumers care needs changed.
* The consumers and representatives confirmed they are involved in the care planning process, such as through face to face discussions and phone conversations with the registered nurses. Some sampled consumers have received a copy of their care plans.
* The representatives interviewed said they have discussions with the registered nurses when their consumer’s health needs change or when an incident occurs. They said ongoing discussions may involve the use of specialists or allied health therapists to assess and assist in the ongoing care of the consumer.

However,

* The service does not have an effective system in place to ensure the consideration of risk to consumer’s health and well being has been managed appropriately to ensure the consumers’ safety. The organisation has a documented process for the initial assessment and care planning for new and existing consumers but was not able to demonstrate these processes are consistently being implemented to manage risk.
* The Assessment Team identified for some sampled consumers when incidents occur, the investigation, cause and what has been implemented to minimise the incident reoccurring has not been completed and documented to guide staff practice in the management of their care.

**Requirement 2(3)(a)**

The Assessment Team found that the service does not have an effective system in place to ensure the assessment of risk to consumers health and wellbeing is being managed appropriately. Although some risks have been identified and risk activity care plans completed, this was not consistently identified when reviewing the sampled consumer clinical documentation. For consumers with beds against the wall, low low beds and bedrails in use the service has not completed a comprehensive risk assessment to determine the suitability of the equipment with regard to the consumer’s safety and the use of the device. In regard to ensuring the bed rails are fully functional, there is no monitoring program in place to ensure the bedrails are secured to the bed securely and no rust or sharp edges are present to potentially cause harm to the consumers. The Assessment Team found consumers had not been asked to consent for the use of devices that may restrict their freedom of movement or pose a safety risk to them. The Assessment team observed that consumers in the memory support houses 4 and 5 have environmental restraint in place and consent had not been obtained. The Assessment Team also identified that some consumers in houses 6 and 7 are environmentally retrained as these houses have a key coded entry/exit and the code to exit is not displayed near the doorway. Staff said they only provide the exit code to consumers who are not at risk of wandering resulting in consumers who have the potential to wander being environmentally restrained without the appropriate consents in place.

The Assessment Team identified a consumer on anti-coagulants and this was not reflected as a risk in his risk activity care plan. Another consumer with a Stage 2 pressure injury did not have this injury identified in either his risk activity care plan or his skin care plan. A third consumer with a history of multiple falls was not reassessed for her falls risk following her return from hospital after sustaining a fractured nose, neither was a risk assessment completed for this consumer after she choked on food. A fourth consumer with a history of falls was not reassessed for his falls risk after his return from hospital following a fall and he did not have a current risk activity plan in place.

The Approved Provider, in their response to the Assessment Team’s report, acknowledged that risk assessment and consent had not been consistently documented for the consumers sampled by the Assessment Team. The Approved Provider argued that as consumers had requested the use of these devices including bed rails and low low beds consent had been obtained verbally and each device had been deemed suitable for the consumer’s use as per the resident’s risk/restraint activity review plan. The Approved Provider, however, did not supply evidence of a consumer’s risk/restraint activity review plan to support their statement that a risk assessment had been completed prior to the use of these devices. With regard to supervising the use of these devices, the Approved Provider stated that they only buy from reputable sources and that equipment is regularly inspected to make sure it is safe for use.

With regard to environmental restraint, the Approved Provider stated that the exit code for houses 4 and 5 used to be displayed near the doors to the Memory Support Unit but they have ceased to do this to better manage infection control during the COVID-19 pandemic. They argued that consent for environmental restraint had been obtained from the appropriate person during the entry process when accepting placement for the consumer in the Memory Support Unit. The Approved Provider disputed that the doors to houses 6 and 7 are key padded, stating that they have an automatic release button near the doors.

The Approved Provider accepted that neither the consumer on anti-coagulant therapy or the consumer with a Stage 2 pressure injury had these risk included in their assessment and care planning documentation. The Approved Provider did not provide further information in relation to the third consumer and the apparent failure to assess their falls and swallowing risk. With regard to the fourth consumer, the Approved Provider submitted a Falls and Other Risks/Safety Assessment completed on 2 June 2022 (some three months after the consumer’s last fall on 12 March 2022) as evidence of assessment completed. The Approved Provider also submitted a physiotherapy care plan commenced 17 December 2022 and physiotherapy progress notes between 4 January 2022 and 25 March 2022. On review, I note, the physiotherapy notes provided made no reference to assessment of the consumer following a fall. The Approved Provider stated the consumer has a current risk activity plan but did not include this in their response.

I have considered the Assessment Team’s report and the response by the Approved Provider. I find that assessment and planning does not routinely follow when a risk to the consumer’s health and well-being is identified to inform the delivery of safe and effective care and services. This is evident in relation to risks associated with skin integrity, falls, chocking, the use of anti-coagulant therapy and devices such as bed rails.

I note the Approved Provider has stated they have, since the Site Audit, improved their processes in terms of obtaining written consent for the use of potentially restrictive devices/equipment that may present a risk to a consumer. The Approved Provider also included, in their plan for continuous improvement submitted, that they are updating their risk activity assessment to include a more comprehensive risk assessment and environmental audit prior to implementing any kind of restrictive practice/device that may present a risk to the consumer. The Approved Provider also included actions in their Plan for Continuous Improvement to ensure anti-coagulation medication is included in consumer’s risk activity care plan.

I find this requirement non-compliant at the time of the site audit as the service was not able to demonstrate 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.

This requirement is non-compliant.

**Requirement 2(3)(b)**

The Assessment Team found the organisation has policy, procedures, staff training and resources to support consumers’ advance care planning. Review of records for the consumers sampled shows advance care plans are being completed and reviewed as required. Feedback from staff and consumer’s representatives was consistent with this. The organisation has a documented process about the initial assessment and care planning for new and existing consumers, although the service was not able to demonstrate this is consistently occurring for some of the sampled consumers reviewed. The Assessment Team presented evidence with regard to physiotherapy assessments and care plans not being completed in timely manner for two consumers who experienced recent falls as evidence. The Assessment Team also presented evidence regarding two consumers involved in an altercation on 26 March 2022 who were not assessed following the incident and their care plans updated.

The Approved Provider, in their response to the Assessment Team’s report, stated that the Physiotherapist was new and was not sufficiently au fait with using their data management system resulting in care plans not being updated after a consumer had been reviewed. This has now been addressed. For both consumers who experienced recent falls the Approved Provider provided information about assessments and care planning activity conducted to identify and address the consumer’s current needs to manage their falls risk. For one consumer this information included his physiotherapy care plan commenced 17 December 2021, physiotherapy progress notes from 17 December 2021 to 25 March 2022, a GP review 14 February 2022 and a Falls and Other Risk/Safety Assessment completed 2 June 2022. For the second consumer the Approved provider stated a continence assessment had been completed 19 April 2022 and evidence of a family case conference on 31 March 2022, GP review 19 April 2022 and a Falls and Other Risk/Safety Assessment completed 13 June 2022 were provided. In their response the Approved Provider stated that the consumer was assessed by the Physiotherapist on 13 May 2022 but provided no evidence was provided to support this statement.

With regard to the two consumers involved in the altercation on 26 March 2022, it was recommended in the action plan developed following the incident that the male consumer be reviewed by the Physiotherapist. The Approved Provider submitted evidence that the male consumer had been reviewed by the Physiotherapist 27, 28, 29 April and 2 May 2022. The information contained in the physiotherapy notes made no reference to the incident or why the consumer was being reviewed by the physiotherapist.

I have reviewed the evidence submitted by both the Assessment Team and the Approved Provider and have considered the care provided to both consumers. One of the consumer’s entered the service with a prior history of falls. A review of his care and service documentation showed he was assessed by the physiotherapist and a physiotherapy care plan developed on 17 December 2021 following entry to the service. The physiotherapy care plan identified a history of falls. Physiotherapy notes show the consumer was seen by the physiotherapist weekly in January 2022 and monthly in February 2022 and March 2022. This consumer sustained a sustained a fall on 12 March 2022 and was transferred to hospital for a suspected fracture. The consumer returned to the service the same day but was not seen by the physiotherapist till 25 March 2022. The physiotherapy notes for that contact make no reference to the fall 12 March 2022. No further falls assessment was completed until 2 June 2022 when a Falls and Other Risk/Safety Assessment was completed. I find that neither the physiotherapy contact on 25 March 2022 or the falls assessment on 2 June 2022 seem to have been triggered by the fall on March 12 and neither intervention can be considered timely in terms of assessing the consumer’s current needs to inform care planning.

The second consumer had sustained several falls during late March 2022 and April 2022. Whist the service has provided evidence of continence assessment (29 March 2022), GP review (19 April 2022) and family case conferencing (31 March 2022) none of these interventions appear to be sufficiently timely and triggered by the consumer’s ongoing falls. I note the physiotherapist did not review the consumer till 13 May 2022 and the service did not undertake Falls and Other Risk/Safety Assessment till 13 June 2022. I find that neither the physiotherapy contact on 13 May 2022 or the falls assessment on 13 June 2022 seem to have been triggered by the consumer’s falls on and neither intervention can be considered timely in terms of assessing the consumer’s current needs to inform care planning.

With regard to the two consumers involved in the altercation, the Approved Provider was unable to provide evidence that a behaviour assessment was completed until 4 May 2022. Whist the male consumer was reviewed by the physiotherapist he does not have a physiotherapy care plan in place. In addition, there was no further assessment of the male consumer following the incident to assess his diabetes, his mental health or whether pain was the cause of his aggression. No assessments were undertaken of the female consumer following this incident to assess her needs and whether the care plan in place for her addressed her safety, health and well-being.

I have considered the information in the Assessment Team’s report and the Approved Provider’s response and find that assessment and care planning is not routinely occurring to address the consumer’s needs, goals or preferences.

This requirement is non-compliant.

**Requirement 2(3)(e)**

The Assessment Team found consumers’ care and services are generally reviewed for effectiveness. However, for some consumers, care and services were not effectively reviewed for effectiveness when incidents impacted on their needs, goals or preferences. For some consumers when incidents occurred, the investigation, cause and what has been implemented to minimise the incident reoccurring has not been completed and documented to guide staff practice in the management of their care. The Assessment Team identified deficits in the management of an incident involving two consumers in an altercation and the incident and reassessment process that followed to ensure the safety of both consumers. Following the incident a number of actions, seven in total, where identified to assess the care needs of the male consumer involved. There was evidence that only one action had been completed and his care plan had not been updated. There was no evidence that the female consumer’s care needs had been assessed following the incident and her care plan had not been updated. Furthermore, the Assessment Team identified deficits in the management of one consumer’s falls including a failure to take neurological observations post fall on 31 March 2022 at intervals as per the service’s policy. The service also failed to investigate a further four falls she has suffered since the fall causing a nasal fracture on 1 April 2022. This consumer’s care plan was not updated until 13 June 2022 after she has sustained four falls between 1 April 2022 and 6 June 2022. This consumer did not have a physiotherapy care plan and the service could not demonstrate the consumer had received pain assessment following these falls, including the fall which caused the nasal fracture. The Assessment Team identified another consumer discussed in Requirement 3(3)(b) who fell and their neurological observations where not taken at intervals or for the requisite time period post fall as per the service’s policy.

The Approved Provider, in their response to the Assessment Team’s report, accepted that post incident documentation and follow-up had not been attended to following the incident with the two consumers involved in the altercation. The Approved Provider did not dispute that actions identified as required following this incident had not been completed, however, the Approved Provider stated that this incident was escalated and monitored and reviewed at various clinical meetings involving staff at the service.

With regard to the consumer who experienced a fall, the Approved Provider argued that the times recorded in their computer system for when the neurological observations were taken related to the times the observations were entered into the system and not when actually taken. The Approved Provider stated they had identified this issue two months prior to the Site Audit and were addressing it through paper based forms to be completed by staff to ensure timings of observations can be recorded accurately. The Approved Provider did not respond to the issue that the consumer’s neurological observations had not been completed at the correct intervals or for the requisite time period of 72 hours, according to the service’s policy. The Approved Provider acknowledged that the consumer’s care plan was not updated in a timely manner following her falls but pointed to the Falls and Other Risks/Safety Assessment tool completed on 13 June 2022 following her last fall on 6 June 2022 as evidence of ongoing monitoring of this consumer. The Approved Provider stated in their response that this consumer was being monitored following her falls. They stated the consumer had undergone a continence assessment on 31 March 2022 which identified ill fitting shoes (which were replaced), a family case conference was held with her daughter by phone 31 March 2022, an ophthalmologist review was arranged for 5 April 2022, a GP review undertaken on 19 April 2022, and a physiotherapy review undertaken on 13 May 2022 and family case conference planned for 26 May 2022. The Approved Provider also stated that falls assessment and review are discussed at a range of clinical meetings involving staff.

In their response to the Assessment Team’s report the Approved Provider included their Plan for Continuous Improvement. In this plan they have included a number of improvement measures to improve incident management including actions to ensure post incident follow-up is completed, increased clinical governance and oversight of incidents, better reporting on incidents and actions taken and staff education on incident management. The Plan for Continuous Improvement submitted by the Approved Provider identified the need for increased monitoring to ensure neurological observations are carried out post incident as per the service’s policy.

I have considered the Assessment Team’s report and the response by the Approved Provider.

I find the response by the Approved Provider to the incident involving two consumers to be inadequate in terms of assessing both consumers to ascertain if care and services being provided where effective following this incident. Following the incident a number of actions where identified to assess the care needs of the male consumer involved which were not completed and his care plan had not been updated. There was no evidence that the female consumer’s care needs had been assessed following the incident and her care plan had not been updated. Whilst I acknowledge the statement by the Approved Provider that these incidents where discussed in various meetings these meetings do not appear to have resulted in action to address the individual needs of each consumer.

With regard to the consumer who sufferednumerous falls - the Approved Provider stated the consumer had undergone a continence assessment on 31 March 2022 but provided no evidence to support this, neither was there evidence that the planned ophthalmology review occurred. Evidence of GP review on 19 April 2022 was provided but no evidence that the planned review of the consumer’s diabetes management plan was followed up with the GP after 21 April 2022. Neither was evidence provided of the physiotherapy assessment undertaken on 13 May 2022 or the family case conference on 26 May 2022. There appears to have been no further documented evidence of review of this consumer after the GP review on 19 April 2022 until 13 June 2022 when the consumer’s care plan and falls assessment was updated.

I, therefore, find the response by the Approved Provider to be inadequate in terms of reviewing the effectiveness of care and services provided to these sampled consumers.

I find this requirement non-compliant as the service was unable to demonstrate 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.

This requirement is non-compliant.

**Standard 3**

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

Overall sampled consumers considered that they receive personal care and clinical care that is safe and right for them.

For example:

* Overall consumers and representatives interviewed by the Assessment Team considered the consumers receive personal care and clinical care which is safe and right for them. For example, 3 consumers and 5 representatives spoke highly of the clinical care the consumers receive.
* Review of organisational policy, procedure, resources and interviews with staff show there is support available for consumers nearing end of life. For one sampled consumer who was nearing end of life, review of their care and services records showed their comfort and dignity were maintained. Feedback from the representatives was positive.
* The service demonstrated practices in place for recognising and responding to consumers deterioration or change in condition. Review of sampled consumers care and service documents and interviews with staff shows this is managed.
* Review of documentation and interviews held with consumers, representatives and staff showed information about the condition, needs and preferences of consumers is communicated among staff and with others where responsibility for care is shared. It also showed generally consumers are referred to appropriate services and specialists in a timely manner and in response to the needs of the consumers.
* Some consumers and representatives provided positive feedback in relation to infection prevention and control. There has been support for consumers and staff vaccinations to occur.

Although the feedback from consumers and representatives was very positive in relation to the care the consumers receive, the Assessment Team identified deficits:

* The Assessment Team identified deficits in restrictive practices, skin integrity and pain management. The deficits show some sampled consumers care is not following best practice, is not tailored to the consumers needs and is not optimising their health and well-being.
* In the management of high impact and high prevalence risks associated with the care of some consumers deficits were identified. This includes for falls management, observations which include a neurological recordings and oral care.

**Requirement 3(3)(a)**

Although consumers provided positive feedback in regard to this requirement, the Assessment Team identified deficits in the areas of restrictive practices, skin integrity including wound management and pain management. The deficits show some consumers care is not best practice, is not tailored to the consumer’s needs and is not optimising their health and well-being.

The Assessment Team identified an ineffective system in place for the recording and monitoring of medications used as chemical restraint. Medical reviews were not occurring three monthly (as is the service’s policy) and changes to medications did not have the consent of the substitute decision maker. Additionally, behaviour support plans for consumers prescribed a chemical restraint are not completed as per the Quality of Care Principles 2014 legislation and are not readily available to guide staff practice. The service was unable to demonstrate skin integrity is being monitored adequately to prevent pressure injuries. One consumer, with a high risk of pressure injury, was found to have a stage 2 pressure injury during a fall’s assessment rather than during routine personal care. The Assessment Team also found deficits in wound management. For one consumer, there appeared to be no change in the description of the pressure injury some seven months after the initial assessment of the wound. There was no evidence nutritional supplements to aid wound healing were being provided to the consumer and pain assessment and monitoring has not been completed to ensure the consumer was pain free. Additionally, a wound consultant referral was not considered when the wound had not improved over 7 months. The Assessment Team found that wound care documentation showed a lack of information about the description of the wound in terms of healing/deterioration, exudate, measurement and the type of wound dressings applied. Wound dressings were not occurring as per the dressing regime and wound photography was being taken without a wound measuring tape in the photographs making it difficult to monitor size of wound. With regard to pain management, the service was unable to demonstrate pain monitoring occurred when changes in pain medication occurred for one consumer. In addition, the substitute decision maker was not notified and their consent sought for pain medication to be reduced and later ceased.

The Approved Provider, in their response, did not comment on the lack of pain monitoring for two consumers but included in the Plan for Continuous Improvement education for staff regarding pain management. The Approved Provider stated that, with regard to consent for changes to medication, they were off the understanding the medical officer informed/sought consent from the substitute decision maker but acknowledged they have no record of this as it is not documented. The Approved Provider stated in their Plan for Continuous Improvement that changes will be made to ensure the substitute decision maker is aware of changes to medication and this is documented.

The Approved Provider did not respond to the failure to monitor the skin integrity for one consumer but responded to some of the issues identified in relation to wound care. The Approved Provider argued that staff were using their clinical judgement in not dressing the wounds for the two consumers cited in the Assessment Team’s report as often as prescribed in the dressing regime to lessen disturbance of the wound bed and promote optimal healing. The Approved Provider did not provide a response to concerns that wound care documentation showed a lack of information about the description of the wound in terms of healing/deterioration, exudate, measurement, the type of wound dressings applied and wound photography was being taken without a wound measuring tape. In relation to one consumer, the Approved Provider provided evidence of a dietician assessment on 25 February 2022 as evidence that a consumer was receiving a nutritional supplement to assist with wound healing but provided no further evidence that this was actually being given. The Plan for Continuous Improvement submitted by the Approved Provider includes information that clinical staff will receive additional training in wound care.

The Approved Provider did not provide a response to concerns about the recording and monitoring of medications used as chemical restraint and that behaviour support plans for consumers prescribed a chemical restraint are not completed as per the Quality of Care Principles 2014 legislation and are not readily available to guide staff practice.

I have considered the Assessment Team’s report and the response by the Approved Provider.

I am of the view that deficits have been identified in the areas of restrictive practices, skin integrity including wound management and pain management. With regards to wounds for two consumers not being dressed as per the dressing regime in place, whilst I understand the Approved Provider’s argument that suitably trained staff can use their clinical judgement about how often to dress a wound this decision should be documented in the consumer’s wound care documentation. This was not happening for one consumer with a Stage 2 pressure injury to their right heel making it difficult to understand the dressing regime in place. A second consumer prescribed a daily dressing to a stage 4 pressure injury to their sacrum did not have their dressing documented as occurring daily despite the consumer telling the Assessment Team the wound was dressed daily. Both examples highlight gaps in wound care documentation. Further gaps in wound care documentation around wound description, measurement, and photography were also identified resulting in consumers not receiving wound care that is best practice.

I am of the view that there are deficits in the areas of restrictive practices, skin integrity including wound management and pain management. The deficits show care is not best practice, is not tailored to the consumer’s needs and is not optimising their health and well-being.

I find this requirement is non-compliant as the service was unable to demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: is best practice; is tailored to their needs; and optimises their health and well-being.

This requirement is non-compliant.

**Requirement 3(3)(b)**

The Assessment Team found deficits in the management of high impact and high prevalence risks associated with the care of some consumers. This includes the management of falls including the monitoring of consumer’s neurological observations post fall, pain management and lack of oral care for high risk consumers and the inclusion of anti-coagulant therapy in assessment and care planning.

The inclusion of anti-coagulant therapy in assessment and care planning and the Approved Provider’s response has been discussed in Requirement 2(3)(a). The issue of falls management including the monitoring of consumer’s neurological observations post fall and the Approved Provider’s response to that has been discussed in 2(3)(a), 2(3)(b) and 2(3)(e).

The Approved Provider, in their response, stated that the Assessment team’s finding in relation to oral care was incorrect and they provided information showing oral care provided. With regard to oral care, the Assessment Team identified two consumers where oral care as per their care plan was not being documented as being provided. For one consumer with a tooth abscess required oral hygiene including a therapeutic mouth wash as prescribed by his dentist the Assessment Team found no documented evidence this care was being provided. The Approved Provider submitted the consumer’s hygiene record showing oral care provided between 1 June 2022 to 30 June 2022. Analysis of this information shows none of the entries include mouth wash. Numerous entries make no reference to oral care provided and the remainder have either ‘cleaned teeth’ or ‘cleaned gums’ entered as care provided. When asked by the Assessment Team during the Site Audit, the RN stated she was unaware the consumer had a mouth abscess and was unsure how his oral hygiene was being attended to.

The Assessment Team identified another consumer who has no teeth and a PEG feeding tube in place, who required oral swabbing and tongue brushing to maintain their oral hygiene. The Approved Provider submitted their hygiene record care showing oral care provided between 1 June 2022 to 30 June 2022. Analysis of this information shows no oral hygiene was provided on 19 June 2022 and it was provided only once on numerous days. For the remainder of days oral hygiene was provided twice a day but multiple entries included ‘cleaned teeth’ and ‘cleaned gums’. No entries refer to oral swabbing and tongue brushing. I note in the Assessment Team’s report care staff said they use an oral swab for this consumer but mouth care is often missed. For these consumers a failure to attend to their oral hygiene may have a significant impact on their health and well-being.

In relation to pain management the Assessment Team identified three consumers where there was an absence of pain monitoring. For two consumers pain was not assessed post fall and for one consumer pain was not assessed when he sustained a mouth abscess and pressure wound. This issue was also discussed in Requirement 3(3)(a) and as previously noted the Approved Provider provided no further information in relation to this.

In relation to neurological observations being taken post fall, as discussed in Requirement 2(3)(e), I am of the view that these observations where not taken at intervals or for the requisite time period post fall as per the service’s policy placing two consumers at potential risk of further injury.

I also note deficits in the management of high impact, high prevalence risks associated with the care of consumers in relation to skin integrity and wound management as outlined in Requirement 2(3)(a). Risk assessments have not been completed and consent has not been obtained when restrictive practices have been used as outlined in Requirement 2(3)(a). An incident involving aggression between two consumers as outlined in Requirement 2(3)(e) was not appropriately assessed.

Having considered the issues reflected in this requirement as outlined above I consider the service does not effectively manage high impact or high prevalence risks associated with the care of each consumer.

This requirement is non-compliant.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non- 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

Overall, sampled consumers consider they receive 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. For example:

* Consumers said the service supports and facilitates them to maintain personal and social relationships and remain in contact with people who are important to them.
* Consumers said the service meets their emotional, social, spiritual and psychological needs by way of the internal support provided by staff, other consumers, and volunteer workers.
* Consumers said the service involves other individuals and external organisations to supplement the activity schedules as required or when beneficial to the consumer.
* Consumers said the service provides meals of adequate variety, quantity and quality and which accommodates their dietary requirements.
* Care planning documentation demonstrates each consumer’s condition, needs and preferences are effectively communicated within the organisation and with others who provide services and supports for daily living, and timely and appropriate referrals are made to other providers of care and services as required.
* The Assessment Team observed lifestyle and leisure supports and equipment to be clean, well-maintained, safe and suitable to the needs of the consumer cohort.

However, the Assessment Team identified that while many consumers and representatives said consumers are supported to engage in activities they are interested in, all consumers and representatives advised there are no activities at the weekend and activities in the geographically-removed houses 6 and 7 and in the memory support houses 4 and 5, are insufficient to meet the needs and preferences of all consumers.

# Requirement 4(3)(a)

# The service was able to demonstrate supports for daily living are provided to many consumers that are safe and delivered in line with their assessed needs, goals and preferences, however, not all consumers were either offered or able to participate fully in activities.

The Assessment Team found most consumers who require minimal assistance with mobility and decision-making, and who live in houses 1, 2 or 3 (which have corridors to the main community room where activities are held), receive services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life. However, consumers, who lived in houses 4 and 5 (the memory support units) and houses 6 and 7 did not have the same access to leisure activities.

Consumers who live in houses 6 and 7, advised they can only join in the weekday activities in the main community room if there are staff to support their mobility to get there. A consumer representative of a consumer living in house 6 said there is ‘nothing’ for the consumer to do. One consumer who had lived in house 7 and now in house 2 told the Assessment Team ‘she is glad she now lives in house 2 as she didn’t realise how much she was missing out on when she lived in house 7’. This consumer is a member on the Resident Congress and she told the Assessment Team she told the service they need more lifestyle staff.

Lifestyle staff spoke of activities they were doing to meet the needs of consumers including building a garden bed in the memory support unit for a consumer who likes gardening but advised they cannot meet the needs of all consumers. There are 2 full time and one part staff member who works 2 days a week in the Lifestyle team for 101 consumers. Their duties involve helping consumers with their meals twice a day and driving the bus. Lifestyle staff said consideration of activities are discussed at the consumer meeting where consumers make suggestions on activities or request changes to the activities program, however, they said they were unable to meet some of the requests related to insufficient staff.

The Assessment Team reviewed consumers attendance at activities in the last 18 days. In houses 6 and 7, less than half of the 30 consumers attended the activities offered in the community room whilst the remainder ‘declined activity in community room’. The consumers in houses 6 and 7 have access to one activity a week in House 6, led by volunteers (music appreciation) and three activities in House 7, namely hoy, bingo and reflection. Lifestyle attendance shows no consumer from House 6 or 7 attended hoy in the previous 18 days. Care staff in House 6 advise 10 out of 15 consumers require 2 staff to assist with cares and transfers. Staff said they attempt to invite consumers from House 6 and 7 to activities in the community room, however, their physical care needs limits their ability to attend and, when consumers do attend, they are left in the community room unattended while lifestyle staff assist other consumers. Care staff working in house 6 said they have insufficient time to do anything other than provide required cares.

Representatives of consumers in houses 4 and 5 say it is family or NDIS staff that provide most of the input into ensuring consumers’ wellbeing and quality of life. In houses 4 and 5, care documentation shows consumers attended the following activities; ice cream from ice cream cart, guided walk, visit by volunteer and watching TV. Care staff said most consumers just watch television and some go out with NDIS care workers. The lifestyle team offers the memory support house consumers a foot spa and gardening at 4:00pm each week day and guided walks. During the site audit the Assessment Team saw three consumers being taken on guided walks, however the foot spa and gardening was not occurring in memory support houses on the last two days of the Site Audit. During the Site Audit the Assessment Team observed numerous consumers in the memory support houses and houses 6 and 7 to be seated in front of the television and either sleeping or looking elsewhere. Care planning documentation indicates volunteers visit consumers and most of these visits occur in houses 1, 2 and 3, 6 and 7 with much fewer visit taking place in the memory support houses. Staff said they are pleased representatives and volunteers visit to help keep consumers occupied.

Consumers across all houses advised the Assessment Team they get bored at the weekend if family don’t visit as there are no activities. The Assessment Team reviewed the service’s activity calendar for the months of March, May and June 2022 and identified activities are held five days per week, with no planned activities on Saturday or Sundays.

The Approved Provider, in their response, contended that a few negative individual comments from consumers in the Assessment Team’s report did ‘not reflect views and outcomes for the overwhelming majority of residents’ but provided no information to support this claim in relation to this requirement. The Approved Provider disagreed with the Assessment Teams findings in relation to the lack of activities for houses 4 and 5 and 6 and 7 and referred to a strategic workshop undertaken 24 February 2022 as evidence of their current model. The current model involved a ‘365 day lifestyle, facilitated by Lifestyle staff but a ‘whole of team approach’, with individualised and social group programming, tailored to capacities and interests with special support for dementia and other cognitive deficits’. The Approved Provider provided job descriptions for personal carer and domestic support staff to show their role is part of providing ‘a holistic person centered care model that takes account of the resident’s needs including their physical, emotional, spiritual or social needs’. The Approved Provider stated that residents from houses 4 ,5, 6 and 7 are regularly transported to the main recreational lounge to participate in activities there. In addition, residents in houses 6 and 7 are also able to participate in activities in their own houses including bingo, hoy, music appreciation, prayer and reflection as well as watch the SMART TV and enjoy the courtyard. The Approved Provider stated that consumers in houses 4 and 5 are offered ‘a range of planned activities that are flexibly co-ordinated in response to the prevailing needs of residents’ at that particular time. No evidence was provided to support these claims.

The Approved Provider, in their response, stated that lifestyle staff are only able to capture activity they were directly involved with by way of explaining why a large number of consumers only have activities like ‘ice cream and visit from volunteer’ in their lifestyle notes. The Approved Provider stated that these lifestyle notes do not include activities being offered by others including volunteers and care staff. The Approved Provider stated that scheduled group activities occur six days a week with ‘events and activities frequently scheduled for weekends’ with ‘all staff supporting resident lifestyle and engagement, and this is especially evident on weekends with staff supporting social engagements, interests and hobbies, faith and general ‘downtime’. No evidence was provided by the Approved Provider to support these claims.

I have considered the Assessment Team’s report and the response by the Approved Provider.

# Whilst the AP says lifestyle activity is facilitated by lifestyle staff but is ‘a whole of team approach’ there is no evidence that this occurs. The job descriptions provided for personal carers or domestic staff do not include lifestyle activities as part of their role and both the lifestyle staff and care staff state that they do not have sufficient time to provide activities for all consumers. There is evidence however that volunteers provide lifestyle activities but from the analysis provided by the Assessment Team volunteers are predominantly engaged in activities in houses 1, 2 and 3, 6 and 7 with much fewer visit taking place in the memory support houses.

Based on consumer and staff feedback and the activity schedule, evidence points to organised activities 5 days a week with weekends supplemented by volunteer and family visits with consumers across all houses advising they do get bored at the weekend if family don’t visit as there are no activities. Based on the evidence provided only around 50% of consumers in houses 6 and 7 are attending the activities in the main community room and the activities in their houses are not well attended. I note the Assessment Team observed consumers in houses 6 and 7 sitting sleeping in front of the TV, with only three consumers observed being taken on a guided walk. It is unclear how many activities are offered in the memory support houses with representatives of consumers saying it is family or NDIS staff that provide most of the input into ensuring consumers’ wellbeing and quality of life. The Assessment Team observed the usual activities planned for 4pm in the memory support houses including foot spa and gardening did not happen as scheduled on the last two days of the site audit.

The Plan for Continuous Improvement submitted by the Approved Provider included actions to address issues identified during the Site Audit including conducting an audit of resident profiles to identify activities of interest to consumers, capture records of declined activities and set up an ‘activities hub’ in houses 6 and 7.

I find that, whilst the service has a strategic approach to providing lifestyle activities, not all consumers are being provided with equal access to supports for daily living that are safe and delivered in line with their assessed needs, goals and preferences.

This requirement is non-compliant.

**Standard 5**

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

## Findings

Overall, sampled consumers considered that they feel they belong in the service, and feel safe and comfortable in the service environment. For example:

* Consumers said they feel at home at the service, and their visitors are welcome to spend time with them in their room or in communal areas of the service.
* Consumers and representatives said they are able to easily navigate the service and are able to freely and safely access indoor and outdoor areas.
* Consumers and representatives said that the service environment is cleaned to their satisfaction, and that equipment and furniture is safe, clean and suitable for their needs.

The Assessment Team observed the service environment to be welcoming, clean, well-maintained and easy to navigate. The service has single rooms with ensuites. The service has facilities for consumers and visitors to use, including an activity room, smaller lounge rooms, shaded outdoor areas, café and outdoor walking and relaxation areas. Equipment and furniture were observed to be clean, well-maintained and appropriate for consumer needs.

## Standard 6

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| Feedback and complaints | | Compliant |
| 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

Sampled consumers and representatives said that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken when they do. For example:

* Overall, consumers and representatives said they have few complaints; however, they were satisfied with the way care and services were delivered and they were satisfied with staff.
* Consumers and representatives said they knew how to make a complaint if they needed to and when they had raised issues in the past, staff and management always responded promptly. Most said if there was an issue, they would raise it with a registered nurse, care staff or the director of nursing and it would be addressed.

The service uses the organisation’s systems to support and encourage consumers and representatives to provide feedback or make a complaint and to manage and respond to complaints.

While the organisation’s complaints form is readily accessible to consumers and representatives, management accepts complaints either written or verbally.

Records evidence management responds to feedback and complaints and acts to address complaints when they are raised.

Feedback and complaints link with the organisation’s continuous improvement process.

## Standard 7

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| Human resources | | Compliant |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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

Most sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

For example:

Overall, sampled consumers consider that they receive quality care and services when they need them and from people who are capable and caring. For example:

* Consumers confirmed staff are kind, caring and respectful of their identity, culture and diversity.
* Consumers stated they believed staff had adequate training and knowledge to appropriately deliver safe quality care and services.

During the Site Audit, all interactions between management, staff, and consumers and representatives were observed to demonstrate a kind, caring and respectful approach.

The service demonstrated there are established performance management and development processes for staff, and there are defined role descriptions for all positions at the service.

However:

Due to shortages in lifestyle staff, consumers do not have access to activities and/or staff to support services for daily living. While the service is aware of the issue and endeavouring to ensure sufficient numbers of lifestyle staff, the current staff shortage has resulted in ongoing adverse outcomes for consumers.

**Requirement 7(3)(a)**

The Assessment Team found the service was unable to demonstrate the number and mix of members of the workforce deployed enables the delivery and management of safe and quality care and services. Consumers reported a lack of lifestyle staff and relevant activities to promote their well-being. The Assessment Team observed consumers being positioned in the same position for extended periods of time and not engaged in any activities they are interested in.

The Approved Provider, in their response, contended that staffing levels ‘across the board’ are sufficient to respond to calls for assistance and provide clinical and personal care. The Approved Provider argued that there is plenty of evidence in the Assessment Team’s report of positive engagement between consumers and staff to show that consumers are supported and their emotional, psychological and social needs are being met.

# I have reviewed the Assessment Team’s report and the Approved Provider’s response. I am of the view that, whilst the Approved Provider needs to address the issues identified in relation to ensuring supports for daily living are provided that are safe and delivered in line with each consumer’s assessed needs, goals and preferences the workforce is sufficiently enabled to provide for the delivery of safe and quality care and services.

This requirement is compliant.

## Standard 8

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

## Findings

Overall sampled consumers considered the organisation is well run and that they can partner in improving the delivery of care and services.

For example:

* Consumers and representatives interviewed said the service is well run and they are invited to provide feedback on the care and services through surveys, consumer and consumer congress meetings, feedback forms and face to face discussions with staff and management.
* Representatives said management communicates with them regularly and they are kept informed of changes impacting the delivery of care and services, including COVID-19 visitor restrictions.
* Management communicates with the Governing Board (the Board) to ensure the organisation delivers safe and quality care and services to consumers.
* The chief executive officer, who is a Board member, attends morning meetings on site every weekday to ensure open lines of communications are kept between levels of hierarchy and the Board is well informed of matters at the service level.
* The organisation has implemented effective organisation-wide governance and risk management systems and practices to prevent and manage incidents and to identify and respond to abuse and neglect of consumers, including serious incident reporting through SIRS.
* The organisation has policies and procedures documenting the consumer’s right to take risks. Documentation and care practices including risk identification and management processes, risk mitigation strategies and a clinical governance framework outlining accountability, roles and responsibilities exist.
* The service demonstrated that effective organisation wide governance systems are in place relating to information management, continuous improvement, financial governance, workforce governance (including the assignment of clear responsibilities and accountabilities) and feedback and complaints.

In relation to managing high impact or high prevalence risks, the service did not demonstrate it effectively manages high impact, high prevalent risks for consumers relating to falls, skin integrity and wound management. In addition, risk assessments have not been completed and written consent not obtained when restrictive practices have been used in relation to environmental and mechanical restraints. Furthermore, an incident involving aggression between two consumer was not effectively investigated to identify the cause and re-assessment of both consumers not undertaken to minimise risk and ensure their safety.

**Requirement 8(3)(c)**

The Assessment Team found the service demonstrated effective organisation wide governance systems are in place relating to information management, continuous improvement, financial governance, workforce governance (including the assignment of clear responsibilities and accountabilities) and feedback and complaints.

The Assessment Team recommended that this requirement was non-compliant as some consumers subject to restrictive practices did not have the required documented assessment or consent in place and an incident involving two consumers was not effectively managed.

The Approved Provider, in their response, disagreed with the Assessment Team’s findings stating that that they have substantial amount of structure and systems for good governance with regard to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints.

I have considered the Assessment Team’s findings and the Approved Provider’s response. I have chosen to consider the issues of restrictive practices and incident management under Requirement 8(3)(d). Given the Assessment Team’s findings in relation to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints I find this requirement compliant.

This requirement is complaint.

**Requirement 8(3)(d)**

The Assessment Team found the service provided a documented risk management framework, including a risk management plan it uses to identify high impact or high prevalence risks associated with the care of consumers and operations.

However, the service did not demonstrate it effectively manages high impact, high prevalent risks for consumers relating to falls, skin integrity and wound management. In addition, risk assessments have not been completed and written consent not obtained when restrictive practices have been used in relation to environmental and mechanical restraints. Furthermore, an incident involving aggression between two consumer was not effectively investigated to identify the cause and re-assessment of both consumers not undertaken to minimise risk and ensure their safety.

The Approved Provider, in their response, disagreed with the Assessment Team’s findings stating that that they have substantial amount of structure and systems for good governance to support their clinical governance and risk management processes. For example, the service have Circle of Care meetings held every weekdays which focusses on issues such as falls and pressure injuries and regular updates on these matters are provided to the Board and the Clinical Governance Council. The Approved Provider submitted their Plan for Continuous Improvement which identified processes to improve risk management by strengthening their risk mitigation, reporting and governance of high impact high prevalent risks.

I have considered the Assessment Team’s findings and the Approved Provider’s response. Whilst I recognise the service has risk management and clinical governance processes in place I consider that the service needs to strengthen these particularly in relation to risk assessment and the use of restrictive practices to ensure compliance with the Quality of Care Principles 2014. The service’s needs to strengthen their response to incidents to ensure they are effectively managed and prevented. The service also needs to manage risk more effectively by ensuring clinical care provided is best practice with regard to falls management, oral care, wound care and wound care documentation.

This requirement is non-compliant.

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-2)