Performance

Report

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| Name of service: | Performance report date: |
| McLean Care Mackellar Alkira Campus | 6 July 2022 |
| Commission ID: | Activity type: |
| 0354 | Site Audit |
| Approved provider: | Activity date: |
| McLean Care Ltd | 10 – 17 May 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 McLean Care Mackellar Alkira Campus (**the service**) has been considered by Melissa Buhagiar, 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 20 June 2022
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: A total of 4 consumers and 8 consumer representatives were interviewed by the Assessment Team
* the following information received from the Secretary of the Department of Health (**the Secretary**): Exceptional Circumstances determination 16 February 2021.

Additional information: The Assessment Team was on site for the site audit on 10 May 2022 and half a day on 11 May 2022. The remainder of the site audit was completed remotely, via video-conference and telephone interviews and meetings, direct access to the electronic care planning system, and other documentation supplied for review.

# 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 | **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)(b) The approved provider must demonstrate that information relating to cultural identity and/or beliefs, practices and preferences relating to these consumers’ backgrounds is included in their care planning documentation to inform their care. Staff have a demonstrated knowledge of cultural safety.
* Requirement 2(3)(a) The approved provider must demonstrate that assessment and planning, including consideration of risks to the consumer’s health and well-being, is completed in a timely manner, with risks assessed on an ongoing basis to deliver safe and effective care.
* Requirement 2(3)(b) The approved provider must demonstrate that assessment and planning is reviewed and current when the consumer’s condition changes and identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.
* Requirement 2(3)(c) The approved provider must demonstrate that case conferences are held in accordance with the organisation’s policy of within 3 months on entry to the service, annually and if consumer condition changes and is based on ongoing partnership with the consumer and others that the consumer wishes to be involved.
* Requirement 2(3)(d) The approved provider must demonstrate that assessments and planning are effectively communicated and documented in a care plan that is readily available to the consumer and that the there is a system in place to demonstrate consultation.
* Requirement 2(3)(e) The approved provider must demonstrate that care and services are reviewed for effectiveness when circumstances change, or when incidents impact on the needs, goals, and preferences of the consumer. Care plans and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.
* Requirement 3(3)(a) The approved provider must demonstrate that pain, skin integrity and medication management follow best practice and are routinely assessed and/or monitored to ensure that the consumer gets safe and effective personal care, clinical care, or both personal care and clinical care.
* Requirement 3(3)(b) The approved provider must demonstrate that the identified gaps in the management of high impact or high prevalence risks associated with the care of each consumer are have mitigations in place that are regularly reviewed to minimise risk from occurring.
* Requirement 3(3)(c) The approved provider must demonstrate that needs, goals and preferences of consumers nearing the end of life are recognised and addressed, and evident in care planning documentation.
* Requirement 3(3)(d) The approved provider must demonstrate that deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner including follow up actions documented.
* Requirement 3(3)(e) The approved provider must demonstrate that identified deficits are rectified with case conferences regularly held and effective handover of information to staff.
* Requirement 3(3)(f) The approved provider must demonstrate that consumers are referred to services which would support their personal and clinical care, including their wellbeing in a timely manner.
* Requirement 7(3)(a) The approved provider must demonstrate that there is sufficient and appropriate clinical staff to meet the consumers’ clinical care needs and for day to day clinical oversight. The provider must also ensure that there are appropriate numbers of staff to provide personal care and assistance with nutrition and hydration requirements for consumers.
* Requirement 7(3)(b) The approved provider must demonstrate that all staff interactions with consumers and are kind, caring and respectful of each consumer’s identity, culture and diversity and in line with organisational values.
* Requirement 7(3)(c) The approved provider must demonstrate that all staff have the appropriate skills to and knowledge to effectively perform their roles particularly in relation to providing care to consumers with dementia and high needs.
* Requirement 8(3)(c) The approved provider must demonstrate that there are effective organisation wide governance systems relating to this requirement, particularly in relation to ensuring that continuous improvements are actioned and closed out, SIRS is understood by all staff and there are sufficient numbers of staff to provide appropriate clinical, and personal care to consumers.
* Requirement 8(3)(d) The approved provider must demonstrate that there is effective risk management to support managing high impact and high prevalence risks associated with consumers and that strategies are evaluated and reviewed for effectiveness or when circumstances change. The provider must also demonstrate that there are strategies in place to prevent abuse and neglect of consumers and that the incident management system is used to review, investigate and evaluate incidents.
* Requirement 8(3)(e) The approved provide must demonstrate that all staff have a practical knowledge of antimicrobial stewardship, minimising the use of restraint and what restrictive practice involve and open disclosure and the provision of information to consumer and representative following investigation when things go wrong.

# Standard 1

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| Consumer dignity and choice | | Non-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 | Non-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

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

I have assessed this Quality Standard as Non-compliant as I am satisfied the following requirement is Non-compliant:

* Requirement 1(3)(b) Care and services are culturally safe

The Assessment Team interviewed consumers and representatives and who described feeling safe in the service. The management team identified some consumers with cultural backgrounds, however the Assessment Team identified that there was minimal information relating to cultural identity and/or beliefs, practices and preferences relating to these consumers’ backgrounds.

The Assessment Team found that although management were informed and understood cultural safety, staff had limited knowledge or understanding of cultural safety. When asked about diversity in the consumer group a staff member asked what the question meant. Staff were unaware of indigenous celebrations. Review of lifestyle participation records did not identify any NAIDOC activity in 2021 but a Christmas in July celebration was held. All meeting minutes, including consumer meetings, have an acknowledgement of country in their standing agenda. The facility manager said culture is identified when consumers move into the service. She said she believes the planned documentation system will improve identification of culture and has an indigenous specific assessment.

The Assessment Team reviewed consumer’s care planning documentation and noted there was no ‘life story’ or ‘key to me’ document providing any social history.

The approved provider responded to the Assessment Team’s report and the service has used national best practice resources in the development of policy and procedure. This ensures that cultural safety is carried out at McLean Care in a manner that is respectful to the consumers, their representatives and the local communities in which they operate.

I have considered the provider’s response, however find that without the life story and cultural needs documented in consumer’s documentation and the staff’s lack of knowledge of the consumer’s culture, does not demonstrate that care and services are culturally safe.

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

**The following requirements were found to be Compliant:**

* Requirement 1(3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* 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.
* Requirement 1(3)(d) Each consumer is supported to take risks to enable them to live the best life they can.
* 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.
* Requirement 1(3)(f) Each consumer’s privacy is respected and personal information is kept confidential.

The Assessment Team interviewed consumers and representatives who confirmed that they are treated with respect and are valued. Consumers are provided with choices to exercise and maintain independence relating to decision making. The facility manager explained decision makers are identified by the consumer on entry to the service or they have legal documents of their appointed choices.

Consumers and representatives provided feedback to the Assessment Team about being given information to enable them to make day to day choices about the consumer’s care and services. Management and staff across the service spoke of the information provided and communication with consumers/representatives to enable choice. The Assessment Team identified that staff understood the importance of maintaining consumer privacy and spoke about the ways they do this. Observations made by the Assessment Team, while limited, showed consumer privacy was being maintained.

The Assessment Team reviewed consumer documentation and found that consumers are generally supported to take risks to live the best life they can. There is a risk acknowledgment form for consumers and/or representatives to acknowledge if there is some activity they chose to undertake where some risk is identified. Although there are some risk assessments the assessments are not used to mitigate risk to consumers to support their choices and preferences.

# 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. | Non-compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

## Findings

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

I have assessed this Quality Standard as Non-compliant as I am satisfied the following requirements are 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.

The Assessment Team found that assessment and planning, including consideration of risks to the consumer’s health and well-being, is not completed in a timely manner to deliver safe and effective care. The service has a suite of assessments which, when completed, populate the care plan. There is an entry assessment, then further scheduled assessments. Management advised the service is soon to change to a new electronic care planning system to improve consumer assessment making it more person centred.

The Assessment Team interviewed consumers and representatives and found that for one consumer, skin integrity and skin assessment are not completed or up to date with the care plans not including any information about skin issues or risk of related skin breakdown. Another consumer did not have sufficient fluid or hydration and there were no specific interventions to achieve this when the consumer refuses care or displays behaviour.

The approved provider responded to the Assessment Team’s report and advised that the system in place addresses the assessment and planning including consideration to the risks to consumers, however this is not evident at the time of the assessment where risks related to skin integrity, behaviours and hydration were identified and not always reassessed.

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

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.

The Assessment Team found that assessment and planning does not identify and/or address each consumer’s current needs, goals and preferences, including advance care planning and end of life planning. There is limited consumer information evident for end of life planning, or information identified in review of consumer files. The Assessment Team found that assessments are not always reviewed or current when consumer condition has changed and consumer goals and preferences relating to end of life are not identified.

The Assessment Team interviewed management who advised there is currently no system in place for monitoring who has a current end of life plan. Management were unable to provide information as to the number of consumers who have end of life plans. The service’s palliative care policy directs annual review of advance care directives; this has not occurred. Most advance care directives reviewed are several years old, one noted to have been signed in 2013.

The approved provider responded to the Assessment Team’s report and advised that their internal quality and continuous improvement processes had identified that improvements could be realised in documentation and this was (and continues to be) discussed at a range of forums with various resources to assist staff. The internal review of all consumers at the service, but particularly any consumers named in the report occurred as a high priority following receipt of the report. I acknowledge the immediate action the provider has initiated; however, I find that the approved provider is not compliant with this requirement at the time of assessment.

Requirement 2(3)(c) The organisation demonstrates that assessment and planning:

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

includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

The Assessment Team found that assessment and planning is sometimes based on ongoing partnership with the consumer and representative. Management acknowledge case conferences have not been held in accordance with the organisation’s policy of within 3 months on entry to the service, annually and if consumer condition changes. This was identified for consumers and feedback from the representatives who advised that they did not feel that they were a partner in assessment and planning and had not for some time. The provider did advise that improvements are underway to ensure case conferences are current.

The approved provider responded to the Assessment Team’s report and advised that they agree with the evidence presented in the report that outlines this requirement not being met to the standard required. The provider advised that since the site audit, corrective actions have been taken and this is overseen by the Director of Residential Services NSW and executive leadership team and monitored via formal reporting processes.

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

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.

The Assessment Team found that assessments and planning is not effectively communicated and documented in a care plan that is readily available to the consumer. The Assessment Team interviewed management who said consumers can have access to their care plan if they want to; they said privacy issues were identified and they found the consumers would leave the care plan about. They said care plans are discussed at case conferences. They said some consumers will ask about care provision and they will email to family members if requested. Management advised that the current electronic care planning system doesn’t have a system to demonstrate consultation.

The Assessment Team identified that case conferences have not been regularly held. There was inconsistent feedback about consumer and representative awareness of, and access to, care plans. Consumer representatives said they are generally informed about incidents and have regular conversations with staff members.

The approved provider responded to the Assessment Team’s report and advised that corrective actions were undertaken at the time of the site audit to address these deficits as a high priority and overseen by the Director of Residential Services NSW and executive leadership team and monitored via formal reporting processes.

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

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.

The Assessment Team found that the service does not demonstrate that care and services are reviewed for effectiveness when circumstances change, or when incidents impact on the needs, goals, and preferences of the consumer. Care plans are not regularly reviewed and are not reviewed following incidents. Care plans are expected to be reviewed third monthly, however it was found care plans and assessments are not all current. Management were unable to provide information about how many care plans and assessments are overdue.

The Assessment Team found that consumers are generally reviewed by the physiotherapist following falls.

The approved provider responded to the Assessment Team’s report and advised they had identified the lapse in review of care plans according to a 3 monthly schedule and case conferences with consumers and representatives not occurring and have taken actions to implement a schedule for the service to follow and commence recruitment for an additional registered nurse.

I acknowledge the immediate attention the provider has initiated however find that the approved provider is not compliant with this requirement.

# 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. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

## Findings

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

The following requirements have been assessed as Non-compliant.

Requirement 3(3)(a) 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.

The Assessment Team found that the service does not demonstrate consumers get safe and effective personal care or clinical care that is tailored to their needs and preferences, supports their health and wellbeing, or that is best practice.

The Assessment Team identified that pain and medication management were not best practice and does not optimise consumers wellbeing. Pain is not routinely assessed and/or monitored for consumers with conditions which may result in pain. Pain is not monitored for consumers following incidents or those with wounds. When staff do assess pain they routinely document no or mild pain in consumers who evidently have pain, even at the end of their life. Efficacy of as needed medications is regularly not documented, and monitoring notes are frequently delayed; usually documented 24 hours after the medication administration and at times longer with a recent note documented 4 days after the as needed medication administration.

The service does not have a Registered Nurse on night shift or on weekends as it has traditionally been a low care service, with staff advised to contact the organisations other service if a Registered Nurse is required. Medication incidents show staff do not have skills or oversight to ensure medication management is best practice. There is negative impact on consumers as a result of this and also potential risk to consumer wellbeing.

The approved provider responded to the Assessment Team’s report and advised that they have identified some gaps and areas for improvement and continuous improvement to be a fundamental element of the delivery of clinical care and personal care with incidents occurring, the service have systems in place (learning management systems, care record systems) and policies, procedures and guidelines to direct practice and effective quality systems to measure if this is being achieved (including auditing, incident management and reporting, complaint management). The service states that the incident reporting for medication incidents is positive in order to address the gaps and skills of staff.

I acknowledge the approved provider response, and their continuous improvement activities, however find that there are areas identified by the team that do not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care.

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

Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team identified gaps in the management of high impact or high prevalence risks associated with the care of each consumer. The service has a risk rating system for incident management although identified risks do not always have effective strategies to minimise risk. Management following incidents does not always mitigate risk.

The Assessment Team spoke with management who said while there was an increase in high impact and/or high prevalence risk to consumers at end of 2021 and early 2022 this has been managed. Management advised that consumers’ skin integrity and skin tears was the most prevalent risk to consumers. COVID-19 was also identified as a high impact and high prevalence risk to consumers. The Assessment Team was told the local area has a high transmission rate of the infection which has impacted on the service.

There has been high incidence of falls in the service. A consumer who has high risk of falls has not had improvements made to safety and risk mitigation have been unsuccessful. Medication management was not identified as a high prevalence high impact risk to consumers.

Behaviour management was not identified as high impact high prevalence risk. Staff do not have effective behaviour management skills for behaviour support of the consumers. Incidents of aggression have potential risk for consumers and others.

The approved provider responded to the Assessment Team’s report and advised that the service has proactively implemented an incident management system and risk framework (with associated risk matrix) based on best practice as in use by all state health departments and large not for profit providers nationally in 2019. The system has successfully ensured that the organisation, each service, and staff are able to clearly determine harm (i.e. – severity) which guides internal escalation procedures and quality reporting (for example tracking and trending incident rates over time whilst also determining when incidents must be investigated by the Clinical Governance or the Quality and Risk Team.

I acknowledge the providers response; however, it is not evident that there are sufficient strategies in place to prevent high impact and high prevalence risks from reoccurring or that the mitigation strategies are re-evaluated when unsuccessful, with new strategies developed.

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

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.

The Assessment Team reviewed care planning documentation and found that there was limited end of life assessment or planning evident. There was no involvement of palliative care teams or specialised services or allied health. It is evident from documentation staff are generally compassionate in their care of consumers. There were progress notes about consumers regarding pain management, when they are identified as having pain. End of life wishes are not recorded in the care plan and are not evident in other computerised documentation. Some consumers have a paper document advance care directive although most are not current. There are currently no consumers requiring palliative care at the service.

The Assessment Team spoke with management who advised that there is only one palliative Registered Nurse in town who does not work full time and does not cover residential aged care services. Management advised that there are plans to arrange telehealth to support palliative care provision although this has not yet occurred.

The organisation’s palliative care policy, including the palliative medication policy, provide guidance and information relating to organisational expectations. The policies promote early discussions about end of life goals and preferences and a multidisciplinary approach neither of which was evident at the service. The policies focus on assessment of need and pain relief which was not evident in documents reviewed. There is a palliative care plan template which was not evident in documentation reviewed.

Management said the organisation has contracted ELDAC to provide palliative training to staff. They said they hope the training might have impact on the medical officers who provide services at the service.

The approved provider responded to the Assessment Team’s report and advised that due to the ‘health crisis’ the NSW Health policy is that palliative care nursing specialists are only able to provide review or care for patients currently admitted (either as inpatients or outpatients) to NSW Health. The organisation is currently exploring if virtual options would be available for consumers and are in discussions with the Western NSW PHN who have implemented a “Palliative and End of Life Model of Care” for further discussion with the local Hunter New England PHN. Then approved provider agrees that there are some opportunities for improvement in documentation and staff education.

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

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.

The Assessment Team found that deterioration or change in a consumer’s condition is not always recognised or responded to in a timely manner. There have been recent examples where consumers have had unrecognised clinical deterioration resulting in poor outcomes for consumers.

The Assessment Team found that there was a lack of clinical oversight and medical review resulting in care staff being largely tasked with the monitoring of consumers’ conditions and escalation of concerns. The Assessment Team spoke with management who advised that staff are required to identify if the consumer is unwell. The service has a document to provide staff with guidance regarding deterioration in the consumer.

The approved provider responded to the Assessment Team’s report and provided examples of where deterioration was effectively responded to however agree that there are gaps in the documentation, with follow up actions not being documented routinely. The provider advised that this has been included in corrective actions that have been implemented as a priority at the service.

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

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.

The Assessment Team found that information about the consumer’s condition, needs and preferences is not always documented and communicated within the organisation, and with others where responsibility for care is shared. Deficits were identified with the communication to medical officers. Case conferences with consumers and representatives have not been routinely held. The Assessment Team spoke with management who advised that the current electronic care planning system does not meet the service’s needs. Staff provided feedback to the team that handover of information is not always effective and that handover following incidents does not always occur.

The approved provider responded to the Assessment Team’s report and advised that due to the service being behind in case conferences, this has impacted on the information about the consumer’s current condition, needs and preferences being documented and communicated effectively and as noted in previous requirements, they have identified high priority corrective actions that have been implemented on receipt of the Assessment Team’s report.

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

Requirement 3(3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

The Assessment Team identified that the service has not been able to refer consumers to services which would support their personal and clinical care, including their wellbeing. Services to support clinical and pain management, palliative care and, for some consumers, behaviour management have not been regularly accessed.

The Assessment Team found that the service has a referral system although it is at times ineffective. There are some allied health providers who regularly visit the service, including podiatry and the physiotherapist. Currently there is a physiotherapist on site most days who supports consumer mobility and pain management. The service has access to medical officers.

The Assessment Team interviewed management about clinical oversight and were advised there are no really complex care requirements in the service. They said after hours, including on weekends, staff will consult the Registered Nurse at the organisation’s other local residential aged care service if they have any concerns or require clinical direction.

The Assessment Team found that although some consumers have been reviewed by specialist behavioural services, others have not. The Assessment Team also identified that in some instances timely and appropriate referrals to medical officer had not occurred or the consumers were unable to be reviewed by the medical officer within a timely manner.

The approved provider responded to the Assessment Team’s report and advised that whilst they suggest that there is evidence that the service is meeting parts of this requirement, and that some elements of this requirement are beyond the control of the organisation, they would suggest, that there have been instances identified in the report where documentation is not to the standard required and that this has the potential to impact on timely referrals. The approved provider has put in place corrective actions as a high priority and reviewed all consumers to ensure consumer safety.

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

The following requirement was found to be Compliant.

Requirement 3(3)(g) Minimisation of infection related risks through implementing:

standard and transmission-based precautions to prevent and control infection; and

practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The Assessment Team found that the minimisation of infection related risk is sometimes occurring at the service through standardand transmission-based precautions to prevent and control infection, and by developing practices to promote appropriate antibiotic prescribing and use. The Assessment Team spoke to management who advised that antimicrobial stewardship (AMS) resources are available and considered by staff and confirmed there are minimal infections.

The Assessment Team identified that there is a consumer and staff vaccination program in place. There was a recent COVID-19 outbreak at the service, which was contained and there was minimal impact on consumers. COVID-19 precautions remain in place. Although gaps were identified in antimicrobial stewardship, on balance this requirement is recommended as compliant.

# Standard 4

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| Services and supports for daily living | | 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. | 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

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

The following requirements have been assessed as 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.
* Requirement 4(3)(b) Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

The Assessment Team found that there is spiritual support provided in the service which meets the needs of consumers. Currently an Anglican and a Catholic minister visit the service for church services and to provide consumers with individual support as requested. The Assessment Team identified that staff demonstrate understanding of consumer emotional needs and provided information as to how they provide support to consumers. However, the Assessment Team noted that there were some gaps in emotional support provision for consumers and staff documentation of social history or psychosocial needs is not evident for all consumers.

The approved provider responded to the Assessment Team’s report and provided further evidence of the documentation supporting their compliance with this requirement.

* Requirement 4(3)(c) Services and supports for daily living assist each consumer to:

participate in their community within and outside the organisation’s service environment; and

have social and personal relationships; and

do the things of interest to them.

* 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.
* Requirement 4(3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 4(3)(f) Where meals are provided, they are varied and of suitable quality and quantity.
* Requirement 4(3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained.

The Assessment Team found that overall consumers and their representatives said they get safe and effective services for daily living and staff support them to optimise their independence, well-being, and quality of life.

The Assessment Team interviewed staff who advised that the service is predominately a low care facility, so consumers are generally able to come and go as they please. They said some consumers go out all the time and if they want something specific staff can take them out on an individual basis. Staff advised that a risk assessment is completed about where they want to go or how they access a car or taxi and review the outcome.

It was demonstrated that services and supports for daily living assist each consumer to participate in their community within and outside the service’s environment. Consumers are supported to have social and personal relationships and to do the things of interest to them. Consumers have been supported with phone calls and videoconferencing during the COVID-19 lockdowns.

The lifestyle continuous improvement plan (CIP) includes staff assist consumers to maintain a daily rain chart and also to put seasonal flowers on dining tables. The rain chart was observed posted in the communal area and flowers were observed on the dining tables. The service provides workbooks tailored to the consumers’ interests with puzzles and quizzes.

Consumers said the resident meetings ensures they are informed of activities and changes in the service. There was evidence of communication with providers of spiritual services and national disability insurance scheme (NDIS) services.

# 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

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

The following requirements have been assessed as 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.

Requirement 5(3)(b) The service environment:

is safe, clean, well maintained and comfortable; and

enables consumers to move freely, both indoors and outdoors.

Requirement 5(3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The Assessment Team interviewed consumers and representatives who advised the service environment is welcoming and homely. The Assessment Team’s observations are that the service environment is welcoming and optimises a sense of belonging and interaction. Consumers were seen gathering in the main lounge area, socialising with each other. Management advised they know that consumers and representatives are made to feel welcome, and consumers to feel at home in the service, through speaking with them and from their feedback, including via surveys. Recent survey results show respondents thought consumers felt at home in the service.

The Assessment Team’s observations are that some elements of dementia enabling design are evident in the service environment, but this has not been optimised to support functioning of consumers living with cognitive impairment. For example, there are limited visual cues to help consumers recognise their room door and to find their way around the service. The Assessment Team did not identify significant impact on current consumers. Consumers and representatives predominantly provided positive feedback about the service environment, including that it is clean, well maintained and comfortable.

The furniture, fittings and equipment provided for safety, comfort, independence, function and enjoyment in the service environment are predominantly clean, safe and well maintained. Consumers, representatives and staff provided information about this. Management spoke of new furniture provided, including for the lounge and dining room, and staff of being able to access suitable equipment for consumers when it is needed. Observations made by the Assessment Team confirmed all of this.

# 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

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

The following requirements have been assessed as Compliant.

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

The Assessment Team interviewed consumers and representatives who confirmed that they feel comfortable giving feedback or making a complaint.

The Assessment Team observed feedback and complaint mechanisms are promoted in the service environment, with posters, brochures and a feedback box provided. Management and staff interviews demonstrate a culture of openness and that feedback and complaints are welcomed as an opportunity to improve.

The Assessment Team found that consumers and representatives have been made aware of advocacy and language services and other complaint mechanisms through information in key documents provided to them, and promotion in the service environment of external services. Management advised webinars by the national aged care advocacy organisation have been screened for consumers at the service.

Consumers and representatives in the main advised that when they have given feedback or made a complaint they have felt heard, their feedback has been actioned or complaint resolved, and open disclosure has been practised where relevant. However, one representative said they keep raising concerns or making complaints (about different matters) as problems keep arising; and one representative said they have raised concerns and have not always been satisfied with the outcome of the complaint.

The Assessment Team reviewed documentation which shows ongoing surveying of consumers to gather feedback about the care, services, accommodation and other matters. Information in documentation, such as meeting minutes and the service’s Continuous Improvement Plan, shows the feedback is considered and actioned.

Consumers and representatives advised that improvements are made when they give feedback or make a complaint. Management demonstrated an awareness of complaint trends and gave examples of improvements made or underway in response to consumer feedback and complaints. Review of documentation, such as the survey results, meeting minutes and the service’s Continuous Improvement Plan, shows this occurs.

# Standard 7

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| Human resources | | Non-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. | Non-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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

## Findings

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

The following requirements have been assessed as Non-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.

The Assessment Team found overall that the workforce is planned to enable the delivery and management of safe and quality care and services. However, there is a lack of clinical staff to meet each consumer’s clinical care needs and for day to day clinical oversight; and as deployed the number and mix of staff does not enable the delivery and management of safe and quality care and services.

The Assessment Team interviewed consumers and some representatives who thought there were enough staff to meet the consumer’s needs and preferences and they provided information about staff being responsive. However, some representatives provided contrary information and many of them detailed impact on their relative often noting staff are doing the best they can.

The Assessment Team interviewed sampled representatives and heard that the needs of their consumers are not being met through the numbers of staff deployed. Some examples provided to the team include that there are not sufficient staff to provide assistance to consumers with eating and hydration. A consumer representative expressed concerns about under-staffing and spoke of some impacts on their relative, including in relation to lack of timely toileting/continence care and their relative’s related comfort and dignity.

Another consumer representative said they believed there are insufficient staff available at times to support consumer care. They said there have been instances when their family member did not have access to clinical expertise when required.

The Assessment Team interviewed clinical and care staff who provided information about not being able to complete their work at times, in the allocated shift or in a timely manner. Management advised the service does not have access to temporary (agency) staff. Their staff have been good at picking up extra shifts and working overtime, and 12-hour rosters have been implemented at points in time to overcome challenges with filling rostered shifts.

The Assessment Team reviewed call bell response times for 3 recent days (2, 5 and 7 May 2022), which shows 25 consumer calls answered in more than 5 minutes which is the organisation’s benchmark. Of those 13 were answered in over 10 minutes, ranging from just over 10 minutes to 30 minutes.

More than half of the consumers currently living at the service have been assessed as having high care needs, and in some cases the medical support for consumers has not been optimal, even when consumer change in condition or incidents have been communicated to doctors. The Assessment Team’s findings in Standards 2 and 3 show the number and mix of members of the workforce is not enabling safe and quality care and services. There is a lack of consumer assessment and care planning. There is a lack of clinical care and oversight for consumer health, safety and well-being. Care staff do not always have time to meet consumers’ personal care needs and the needs of some consumers are not being met. Team leaders have not consistently demonstrated they know when to escalate changes in the condition of some consumers for clinical assessment after hours, and there are occasions when this has not occurred.

The approved provider responded to the Assessment Team’s report and provided context to call bell response times where for a six-month period, the response time was within the benchmark except for 0.2% of times. The absence of Registered Nurse on site outside of the 5 day a week roster, with the provision of a Registered Nurse from the organisations other service is noted as the greatest impact for consumers, with a lack of review following clinical incidents. It has also been identified that assessment and planning has fallen behind due to staffing numbers.

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

Requirement 7(3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

The Assessment Team interviewed consumers and representatives who provided feedback that most of the staff are kind and caring. However, some provided feedback that some staff are not kind, caring or respectful. A consumer representative said the staff are mostly kind and caring, but some are abrupt particularly in response to some of the requests their relative makes and this leads to their relative feeling like a burden. Review of documentation made by staff about consumers show they have been unkind, uncaring and disrespectful at times towards some consumers. This shows a lack of support for consumer well-being and has impacted on consumer dignity and comfort.

Representatives of two consumers said their relative has described to them the staff are kind when family are there visiting but are not always kind at other times. One representative, who said the consumer has advised the staff are nice to her when visitors are there but are not nice to at other times. Another representative said while staff were excellent there was one staff member, currently employed, who she described as ‘abrasive’. The representative described instances when some staff were impatient when the consumer requested assistance.

The Assessment Team’s observations, while limited, were that staff interactions with consumers were kind and caring. Staff interviewed spoke about consumers with respect and showed a caring attitude.

The approved provider responded to the Assessment Team’s report and advised that although there is an abundance of information to support that staff are kind, caring and respectful, the feedback from two consumer representatives that this is not always apparent, is not consistent with the organisation’s values.

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

Requirement 7(3)(c) The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team interviewed management, who said staff have been recruited in recent times with the right qualifications for the role. Staff interviewed spoke of having qualifications relevant to their role. Review of a sample of staff personnel records showed those staff have qualifications relevant to their role. However, review of training records shows of the staff who need a cardio-pulmonary resuscitation qualification for their role, 2 have not completed the related training in the last 12 months (with this planned to occur in late May/early June 2022).

The Assessment Team interviewed consumers and representatives who thought that staff had the knowledge they needed to undertake their role and to deliver care and services to the consumer. However, this was not always the case where staff did not identify changes to consumers conditions when behaviour changes were apparent. One representative explained the staff do not seem to understand dementia or know how to care for people with higher level needs, including behaviours. Another representative described that staff do not understand their relative’s condition or a risk associated with their care and despite requests and reminders, staff do not always put the necessary interventions in place for risk mitigation.

Management explained they determine whether staff are competent and capable in their role through performance reviews, observations of staff practice by the facility manager and Clinical Care Coordinator, staff training and competency assessment. Review of training records and a staff competency schedule shows most staff have completed their competency assessments when due. They show team leaders are due to have their annual medication competencies completed in May 2022, having last completed them in May 2021.

The Assessment Team found that whilst team leaders and care staff demonstrated an understanding of the link between behaviour and pain, it is not evident in reviewing the care and services for some consumers. More broadly, it is not evident that staff are able to effectively perform their role in relation to consumer behaviour support. The Assessment Team identified that Behaviour Support Plan obligations were not fully understood and had not been implemented at the service.

The approved provider responded to the Assessment Team’s report disputing the findings and provided information to support their compliance with this requirement. I have considered the information that was provided, however find that although the sample of staff have relevant qualifications to perform their role, the knowledge to effectively perform their roles is not evident in relation to some clinical and behavioural needs of the consumer.

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

The following requirements have been assessed as Compliant

Requirement 7(3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team spoke with management who outlined the orientation processes for new starter staff, which includes formal instruction and training, working alongside other staff in a supernumerary capacity, and completing a job specific staff orientation booklet covering a range of topics.

The Assessment Team interviewed consumers and representatives, who in the main did not think staff needed more training in any areas. However, some consumer representatives thought staff needed more training in relation to caring for people with dementia, communication and medication management.

Staff interviewed across different departments thought they had access to enough training on topics relevant to their work. Although one team leader said they would benefit from training in medication management which has not been provided for some time.

Management outlined the staff mandatory training. Review of related records shows there are high completion rate for the online training, however not in relation to some face to face training. Management explained this has been impacted by COVID-19 related challenges with having trainers come on site to provide the training, and some scheduled training had to be delayed. Some mandatory training that requires completion includes manual handling training, fire safety training, chemical training.

The Assessment Team enquired about training relating to a sample of other topics relevant to the Quality Standards. It was identified that training in relation to medication management had not been provided. Staff also provided feedback to the Assessment Team that although team leaders and care staff have had training relating to some of the clinical tasks they undertake, such as taking consumer vital signs, they do not always feel supported in their roles.

The approved provider responded to the Assessment Team’s report and advised that due to Covid-19 outbreaks both in the service and with providers, it has not been possible to have the face to face component of the training delivered despite all attempts and this has now been rescheduled. The provider has had staff complete the online modules of the mandatory training, which has had high completion rates.

I find that the approved provider is compliant with this requirement.

Requirement 7(3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team spoke with management who outlined the arrangements for regularly reviewing the performance of the workforce and the processes for staff performance management, when needed. Staff said they have participated in regular performance reviews.

Overall, it was demonstrated that regular assessment, monitoring and review of the performance of each member of the workforce is occurring and up to date.

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

## Findings

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

The following requirements have been assessed as non-compliant.

Requirement 8(3)(c) Effective organisation wide governance systems relating to the following:

information management;

continuous improvement;

financial governance;

workforce governance, including the assignment of clear responsibilities and accountabilities;

regulatory compliance;

feedback and complaints.

The Assessment Team found that the organisation has structures, systems and processes for effective governance. Using the Commission’s methodology, effective financial governance has been demonstrated. Effective governance of information management and feedback and complaints has also been demonstrated. However, effective governance has not been demonstrated in relation to continuous improvement, regulatory compliance or the workforce.

The Assessment Team identified that the service’s Continuous Improvement Plan has entries from 2020-2022 and many of them have not been updated or closed out. They lack information about actions taken or include actions with no evaluation of effectiveness. Management advised the Assessment Team that there was a plan to review and update the historical entries in the Continuous Improvement Plan. Management and staff spoke of improvements being made, the Continuous Improvement Plan reflects some improvements are being made and other information gathered corroborates some improvements are being made. However, there is also information showing some improvements made are not being sustained.

The Assessment Team conducted interviews with organisational representatives, service management and review of minutes of governing body and other meeting minutes which shows there has been ongoing oversight of workforce challenges and ways to address them. However, other than the CEO advising they would have more Registered Nurses at the service if they could get them it was not evident that the impact of the ongoing lack of Registered Nurse coverage was understood or being addressed or that the impact of lack of care staff, at times, and their inability to attend to consumers’ needs and preferences, at times, was understood.

The Assessment Team sampled serious incident reporting/incident management system (IMS), restrictive practices and behaviour support planning to assess whether regulatory compliance obligations are understood and applied, with effective organisational oversight of this. The organisation has policy/procedure which entirely or in the main reflects the obligations, and related information and education has been provided and reinforced to management and staff.

The Assessment Team found that management and staff demonstrated an understanding of the serious incident reporting and IMS obligations. Documentation reviewed shows individual incidents are being identified and addressed with serious incident notifications made. However, the factors contributing to consumer to consumer incidents have not been addressed for some consumers sampled and behaviour support and management of related risks has not been optimised to prevent future incidents.

The approved provider responded to the Assessment Team’s report and disputed the team’s findings, however did not provide sufficient information to support their compliance in relation to workforce, continuous improvement or regulatory compliance.

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

Requirement 8(3)(d) Effective risk management systems and practices, including but not limited to the following:

(i) managing high impact or high prevalence risks associated with the care of consumers;

(ii) identifying and responding to abuse and neglect of consumers;

(iii) supporting consumers to live the best life they can

managing and preventing incidents, including the use of an incident management system.

The Assessment Team found the organisation has structures, systems and processes for effective risk management. Organisational representatives provided information about this, which was corroborated through review of related documentation. Some consumers, representatives, staff and management spoke about some sampled consumers being supported to live their best life; and review of some related documentation generally confirmed this. However, effective risk management has not been demonstrated in relation to the other 3 sub-requirements for this requirement.

The Assessment Team found that there is not effective management of high impact or high prevalence risks associated with the care of some sampled consumers in relation to skin integrity, skin tears, falls and behaviours of concern with strategies not evaluated to prevent these risks from reoccurring. Medication management was also found to not be managed effectively.

The Assessment Team requested organisational policy/procedure about prevention of abuse, but none was provided. Management explained that when the SIRS obligations came into effect a number of organisational policies/procedures were consolidated, including about elder abuse, and the new SIRS procedure developed. Review of the SIRS procedure shows it includes guidance about SIRS, but not about preventing abuse of consumers other than listing some possible indicators of abuse.

Organisational representatives said there are safeguards, including mandatory annual education and toolbox training for staff about elder abuse. While management and staff interviewed knew about their role and responsibilities for responding to abuse, they did not demonstrate knowledge of evidence-based strategies for preventing abuse. Overall, it was not demonstrated the organisation has equipped management and staff to have a focus on preventing the abuse of consumers.

The Assessment Team found that the organisation has policy/procedure about incident management to guide management and staff. The Assessment Team’s findings are there has not been effective management and prevention of incidents for some sampled consumers. As noted above, there has been a lack of oversight of service performance by the organisation. While a new risk management system, including to capture consumer incidents is to be introduced, it was not evident that the extent of the gaps was understood or that the system will entirely address them.

The approved provider responded to the Assessment Team’s report and provided a copy of the consumer abuse policy and referenced their previous responses to managing high impact and high prevalence risks. I acknowledge the providers response; however, it is not evident that there are sufficient strategies in place to prevent high impact and high prevalence risks from reoccurring or that the mitigation strategies are re-evaluated when unsuccessful, with new strategies developed.

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

Requirement 8(3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following:

(i) antimicrobial stewardship;

(ii) minimising the use of restraint;

open disclosure

The Assessment Team found that the organisation has structures, systems and processes for clinical governance. Organisational representatives and service management provided information about this, which was corroborated through review of related documentation. However, clinical governance has not been demonstrated in relation to any of the sub-requirements for this requirement.

The organisation has policy/procedure providing management and staff with related guidance and has introduced an infection screening tool. Interviews with staff and review of care and service records for a sample of consumers shows in the main some actions are being taken to ensure appropriate antimicrobial use, in liaison with the consumer, their representative, the treating doctor and through trying to obtain diagnostic test results. However, staff are not always taking actions to prevent infections (such as assisting consumers to remain hydrated) and the Assessment Team notes there has been and continues to be a practice of undertaking regular, monthly urinalysis on all consumers. When this was raised, management was not aware of best practice resources made available on this topic to support AMS.

The Assessment Team found that there are processes to monitor potential restrictive practices including restraint in the service. Management identified potential restraint in the service, however the Assessment Team identified gaps in documentation, review and staff understanding, implementation and oversight of obligations in relation to restrictive practice. The Assessment Team identified that for some consumers bed rails and psychotropic medication had not been understood as restrictive practices.

The Assessment Team found that open disclosure was demonstrated overall in relation to complaints when things are found to have gone wrong. The organisation has policy/procedure reflecting open disclosure should also be practiced in relation to consumer incidents where something has been found to go wrong. There are processes to support this occurs, such as a prompt in the incident report form. While consumer representatives informed the Assessment Team they are told when their relative is involved in an incident, some advised they were not given an explanation of how the incident occurred and/or what would be done to prevent future incidents. No information was provided to show oversight of the practice of open disclosure.

The approved provider responded to the Assessment Team’s report, highlighting other areas of their feedback to demonstrate their compliance with this requirement, however on balance, organisationally the provider has areas for improvement in order to make this requirement compliant.

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

The following requirements have been assessed as Compliant.

* Requirement 8(3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* 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.

The Assessment Team identified through review of records, there is an extensive program of consumer/representative surveying to gain input and feedback and inform the development and delivery of care and services. Management and relevant staff spoke about initiatives that have occurred and improvements made as a result of the input and feedback; and of others planned. Some examples are consumers deciding on new furniture for purchase and designing the Christmas menu. There is also information in the records reviewed showing consumer engagement in the delivery of services. For example, consumers participating in an activity to submit an item for competition at the local fair; and a consumer assisting with some additional tasks to help run a consumer leisure activity, with the consumer confirming this during an interview with the Assessment Team.

The Assessment Team spoke with organisational representatives who described the structures, systems and processes for promoting a culture, and being accountable for the delivery, of safe, inclusive and quality care and services. They gave examples of how this has occurred, including in relation to the service and regarding specific consumers. Interviews with management and staff and the documentation provided, including governing body meeting minutes and reports to the governing body, corroborate this occurs. While it is not evident the extent of some of the service performance gaps have been understood or that actions have been or are being planned and progressed to address them, the specifics of this have been addressed under other governance requirements in this Quality Standard. Overall, it was shown that the governing body promotes a culture of, and is accountable for, the delivery of safe, inclusive and quality care and services to consumers at the service.

1. The preparation of the performance report is in accordance with section 40A– site audit, of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)