Performance

Report

**1800 951 822**

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| Name of service: | Mercy Place Mandurah |
| Service address: | 1 Hungerford Avenue, HALLS HEAD MANDURAH WA 6210 |
| Commission ID: | 7896 |
| Approved provider: | Mercy Aged and Community Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 31 July 2023 to 1 August 2023 |
| Performance report date: | 18 September 2023 |

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 Mercy Place Mandurah (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives and staff;
* the provider’s response to the assessment team’s report received 24 August 2023.
  + The response included commentary and supporting documentation, such as progress notes, monitoring charts, feedback forms and meeting minutes, to refute evidence in the assessment team’s report and to support the provider’s stance. The response also included a range of improvement actions against most requirements, as well as a brief plan for continuous improvement (PCI) outlining issues identified, planned actions and planned completion dates; and
* a Performance Report dated 3 June 2023 for a Site Audit undertaken from 22 March 2022 to 24 March 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-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

**Standard 3 requirements (3)(a), (3)(b) and (3)(d)**

* Ensure staff have the skills and knowledge to:
  + provide appropriate care relating to pain, diabetes and falls, including post falls management; and
* identify deterioration or change of consumers’ condition, implement appropriate monitoring processes and review care and service management strategies to ensure care provided is reflective of consumers’ changed condition.
* Ensure policies, procedures and guidelines in relation to provision of best practice, tailored personal and/or clinical care, management of high impact or high prevalence clinical risks, such as pain, diabetes, and falls, and recognising and responding to deterioration or change in consumers’ condition are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to provision of best practice, tailored personal and/or clinical care, management of high impact or high prevalence clinical risks, such as pain, diabetes, and falls, and recognising and responding to deterioration or change in consumers’ condition.

**Standard 7 requirement (3)(c)**

* Ensure staff competency, skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles, particularly in relation to deficits identified in Standards 3 and 8.

**Standard 8 requirement (3)(d)**

* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks and identifying and responding to abuse and neglect, as well as in relation to the non-compliance identified in Standard 3.

# Other relevant matters:

Requirement (3)(c) in Standard 4 Services and supports for daily living was found non-compliant following a Site Audit undertaken from 22 March 2022 to 24 March 2022. This specific requirement was not assessed at the Assessment Contact undertaken from 31 July 2023 to 1 August 2023.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as three of the four specific requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(a)**

The assessment team were not satisfied each consumer gets safe and effective clinical care in relation to pain, diabetes and falls, with procedures not followed placing consumers at risk. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Four consumers did not have neurological observations taken according to best practice guidelines and organisational policies and procedures following unwitnessed falls.

Consumer A

* Consumer A had a fall in July 2023 and was complaining of pain. Following the fall, pain medication was not given as Consumer A had some two hours earlier. A benzodiazepine medication was given as Consumer A was constantly yelling out, and only later was additional pain relief given as they were still showing signs of pain. In the following days, despite Consumer A expressing pain and spasms and the family asking for the consumer to be provided stronger pain relief, as required pain relief was not given. Pain relief continued to be administered only once a day as the service had been doing for the past 15 days. As required analgesia was not given three times a day as ordered, however, an as required anti-inflammatory was continued daily.
* The representative said Consumer A was moaning in pain when they were awake, but staff said they could not have increased medication. It was only when a senior clinical nurse came in for the Assessment Contact two days later that additional pain relief, an opioid, was organised.

Consumer B

* Consumer B’s diabetes medication was ceased whilst in hospital prior to entering the service. On entry, Consumer B’s blood glucose levels (BGLs) became extremely high, and the family requested the medication be recommenced, which was not done despite the request and medical information available.
* Clinical tests showing Consumer B had glucose in their urine in June 2023 were not responded to. Consumer B’s family requested that diabetic medication be recommenced on the same day which the service did not do. No further urine tests were undertaken over the next two weeks. A pathology report two weeks later and three days prior to a hospital admission, showed very high glucose and sodium levels in the blood. No food and fluid charts were commenced, and progress notes did not show additional fluid or drinks were provided. The following day, doctor’s notes reported Consumer B was very confused which may be the result of dehydration due to high sodium levels.

Consumer C

* Consumer C was not provided diabetic medication due to behaviours. Monitoring of Consumer C’s diabetes stopped and no action was taken when a dietitian raised concerns that Consumer C’s diabetes was not being managed.

The provider’s response included, but was not limited to:

* Shortages of staff, increased use of agency staff and an extended significant outbreak often resulted in decreased or incomplete documentation.
* Acknowledge not all staff documented post falls observations on required charts in line with the pathway; this does not mean observations were not undertaken.
* Improvement actions include undertaking pain management knowledge assessments with care staff and provide targeted training where required.

Consumer A

* There were no concerns regarding Consumer A’s pain management the day after the fall and family raised concerns with staff about pain once which was actioned immediately.
* Consumer A had reported pain in the same location on a number of occasions in 2023, including as recently as two hours before the fall.

Consumer B

* The urinalysis was conducted to check for signs of a urinary infection only. The results were entered into the electronic record and Consumer B was seen by the general practitioner (GP) on the same day with no concerns raised over the urinalysis results.
* The registered nurse entered the representative’s request regarding the medication into the resident review book as the GP was due to visit the following day. GP progress notes show they were aware of the representative’s request and actions they were taking in response. At no time did the GP reinstate the medication.
* Agree staff did not write in progress notes when offering fluids, this is not evidence it did not occur.
* Consumer B’s BGLs were taken daily and were within normal parameters. Consumer B had no clinical symptoms when the reading was recorded as very high. BGLs only became high on the day the consumer was transferred to hospital.

I acknowledge the provider’s response. However, I find the service has not ensured each consumer receives safe and effective clinical care which is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to pain, post falls and diabetes management.

I find neurological observations have not been consistently undertaken post falls, in line with the service’s processes. The provider acknowledges not all staff documented observations on the required charts and asserts that this does not mean observations were not undertaken. By not consistently documenting observations on the required charts, in line with the service’s own processes, I find this practice does not enable effective monitoring of consumers post falls to occur or changes in consumers’ condition to be effectively identified and timely action taken in response.

I have considered Consumer A did not receive care which was tailored to their needs and optimised their well-being following a fall in July 2023. While the provider asserts Consumer A reported pain in the same location on a number of occasions during 2023, I am unable to ascertain the frequency as to which these reports occurred as pain charting, included in the provider’s response, was only from the day prior to the fall. However, I have considered pain charting provided demonstrates from the time of the fall and over the next two days, Consumer A complained of pain in a specific location between two and four times a day. I have also considered that despite Consumer A regularly complaining of pain in the same location following the fall, there does not seem to have been any consideration of providing analgesia to the maximum dosage available to maintain the consumer’s comfort. Additionally, on one occasion, while Consumer A complained of pain, a benzodiazepine prescribed for agitation, was administered. Progress notes included in the provider’s response also indicate Consumer A did not want to get out of bed. The GP was contacted and a narcotic analgesic prescribed two days post the fall.

I find Consumer B did not receive care which was tailored to their needs and optimised their well-being in relation to diabetes management. I have considered Consumer B’s diabetic medication was ceased at the hospital, prior to entering the service and the representative stated prior to entry to the service, Consumer B’s BGLs were steady at around 7.1 mmol/L each day.

Consumer B’s representative is noted to have raised recommencement of diabetes medication with clinical staff five days after entry with the request entered into the GP notes. The GP reviewed Consumer B following a fall, seven days post entry, with progress notes included in the provider’s response indicating the GP would follow up and recommence the medication after undertaking a specific test to monitor blood glucose control. Nine days post entry, a urinalysis showed the presence of glucose. While the provider asserts Consumer B was seen by the GP on the same day the urinalysis was taken with no concerns raised over the results, progress notes from the GP do not indicate they were aware of the results. The GP notation again references the representative’s request relating to recommencement of the medication which the GP indicated would be actioned if blood tests indicate high BGLs. Pathology results from bloods collected 23 days later, included in the provider’s response, do not include results from the specific test. I acknowledge the GP progress note in response to the pathology results indicates high sodium may be due to four different reasons. I also acknowledge the GP progress note does not include any further actions or recommendations in response to the pathology result, including recommencement of the diabetes medication.

The representative stated Consumer B’s BGL readings prior to entry were steady at around 7.1 mmol/L each day. The blood glucose monitoring chart, included in the provider’s response demonstrates BGLs exceeded this level on multiple occasions. In the 17 days post entry, while within reportable parameters, five BGLs are noted above 10mmol/L, up to 19.5mmol/L. In the subsequent nine days, BGLs were taken on seven occasions and were consistently high, with six of the seven recorded between 12.6 mmol/L and 17.7mmol/L. The last BGL is recorded at 32.1mmol/L. I have considered the evidence presented does not demonstrate effective monitoring of Consumer B’s BGLs occurred nor appropriate and timely action taken when BGLs were noted to be consistently high. It was known that Consumer B’s diabetes medication was ceased prior to entry, a specific test had not been conducted to ascertain BGLs overtime, glucose was detected in the urine and BGL readings steadily increased over a 10 day period, prior to Consumer B being transferred to hospital. I have also considered aspects of the evidence relating to Consumer B in my finding for requirement (3)(d) in this Standard.

The documented reportable range for Consumer B’s BGLs were less than 4mmol/L or greater than 20mmol/L. It is not known if these parameters were set by the GP or if consideration was given to what Consumer B’s usual BGL range was prior to entry when setting these parameters. I have also considered reportable ranges for BGLs may not have been individualised to Consumer B. A BGL monitoring chart included in the provider’s response for another consumer, Consumer E, included the same reportable ranges as Consumer B.

I find the evidence relating to Consumer C is more aligned with management of deterioration or change in consumers’ condition. As such, I have considered the evidence in my finding for requirement (3)(d) in this Standard.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)**

The assessment team were not satisfied management of high impact risks in relation to falls, and diabetes was demonstrated. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

Consumer D

* Consumer D was identified as a high risk of falls and had 12 falls in seven weeks between January and February 2023. Documentation does not show Consumer D’s falls were discussed at the clinical meeting to identify further strategies to reduce further risk and injury.
* Consumer D was found on a crash mat on the floor by the bed in February 2023. No obvious injuries were reported but Consumer D was highly agitated. A full set of observations were unable to be obtained following the fall. One partially completed observation was conducted at the time of the fall and not again until 24 hours later. Consumer D was transferred to hospital a week later and diagnosed with a bleed in the brain.
  + Consumer D’s pain was not effectively managed following the fall. Progress notes showed staff were unable to determine if as required analgesia administered was effective. Notes also reported analgesia was not always effective as Consumer D was moaning in pain three days post the fall and had a lot of pain overnight. Following a doctor review four days later, Consumer D was suspected of having a fracture. Consumer D was transferred to hospital for pain and a brain bleed was diagnosed.
* Consumer D’s pain medication was ceased in January 2023 but they remained on   
  as required medication. Although a pain chart showed pain management was effective, progress notes report Consumer D had a lot of pain on movement.
* The service did not identify Consumer D may be at risk when in a bed lowered to the floor as the consumer regularly attempted to get out of the bed to meet their needs. The majority of falls reported Consumer D had been attempting to walk but had fallen. A physiotherapy review five days post the fall said to check Consumer D’s toileting schedule.

Consumer C

* Consumer E did not have BGLs monitored as their behaviours of medication refusal could not be managed. The family were not informed that the medication was stopped due to the refusals. Consumer D developed very high BGLs resulting in transfer to hospital.

Consumer B

* Consumer B was having BGLs checked that appeared on the upper end of the parameters. The service was supposed to assist Consumer B with hydration by pushing oral fluids, but documentation showed this did not occur.

The provider’s response included, but was not limited to:

* Consumer D’s falls were discussed at handovers, with the GP and physiotherapist. All required strategies were in place.
* Consumer D was given analgesia for an elevated temperature on the day of the fall, not for pain. Progress notes state Consumer D was moaning in pain three days post the fall and not before, which is supported by the pain chart, included in the provider’s response. The fall was from a low bed onto a crash mat and should be noted that professional opinion is that it is highly unlikely this fall was the cause of the subdural haemorrhage.
* Improvement actions include:
  + Implementing the requirement for all diabetic consumers to have a diabetes care plan, even when BGLS are not routinely being done, so no BGLs can be documented as a management strategy.
  + Implement a requirement to have an open BGL chart for all diabetic consumers to record when BGLs when a consumer is unwell.

I acknowledge the provider’s response. However, I find for Consumer D, high impact or high prevalence risks, specifically related to falls and pain, were not effectively managed.

The provider asserts Consumer D’s falls were discussed at handovers, with the GP and the physiotherapist. Progress notes included in the provider’s response indicate a full review of falls by the GP and two post fall reviews by the physiotherapist. The progress notes do not, however, demonstrate that a comprehensive review of Consumer D’s falls management strategies occurred or that new strategies were implemented to reduce the risk of further falls and injury. This includes review of the use of a bed lowered to the floor which, as Consumer D attempted to get out of bed, placed them at risk of falls and injury. While I acknowledge establishment of a falls prevention team, this was not until April 2023.

I have considered a pain chart included in the provider’s response demonstrates pain levels were monitored, with the chart indicating Consumer D did not express pain until three days post the fall and again the following day. However, I have placed weight on information included in the assessment team’s report which indicates following the fall, Consumer D’s mobility declined and they displayed signs of aggression towards staff. Progress notes also indicated analgesia was not consistently effective as Consumer D was moaning in pain three days post the fall and had a lot of pain overnight. This information was supported by a progress note entry included in the provider’s response which stated Consumer D was very aggressive during activities of daily living and was groaning in pain whenever their leg was touched. While the progress note states analgesia was administered, this is not reflected in the pain chart. As such, I have considered by staff using two different sources to document actions taken in response to a consumer’s pain, this does not enable effective monitoring of a consumer’s overall pain experience to occur or ensure their comfort is maintained. I have also considered aspects of the evidence presented for Consumer D in my finding for requirement (3)(d) in this Standard relating to management of deterioration or change in a consumer’s condition.

In relation Consumer B, I find the evidence presented aligns with the intent of requirement (3)(a) in this Standard, that is provision of care that is tailored and optimises consumers’ health and well-being. As such, I have considered this evidence in my finding for requirement (3)(a) in Standard 3. In relation to Consumer C, I have considered the evidence in my finding for requirement (3)(d) in this Standard.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(d)**

The assessment team were not satisfied deterioration in a consumer’s health status is recognised and responded to in a timely manner. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

Consumer E

* Consumer E’s medications, including medications relating diabetes, were ceased in October 2022. Notes indicate medication was ceased due to ongoing refusal. Consumer E’s BGLs were not monitored.
* Consumer E was reviewed by a dietitian in December 2022 due to weight loss. A three kilogram weight fluctuation was noted with the dietitian querying whether this was a normal fluctuation. The dietitian noted they could not find any BGL records for Consumer E and reported their concern with care staff relating to foods given to Consumer E, BGLs and diabetes.
* The dietitian’s concern was not followed up with BGL monitoring and deterioration in Consumer E’s clinical status was not identified. Notes nine days post the dietitian review report, Consumer E was highly agitated, very aggressive and would not allow staff to provide personal care. Consumer E then settled when the representative came, allowing personal care.
* Eleven days later, care staff reported Consumer E was unwell and was only responsive to a loud voice and could not communicate properly. They were severely weak and had a tremor. A BGL reading was unable to be obtained as it was too high to measure. Later in the day, notes said Consumer E was too drowsy, not responding, was unable to be assisted with lunch as they were too drowsy and at risk of choking. Notes reported the registered nurse would consider transfer to hospital if Consumer E’s symptoms deteriorated. Consumer E was later transferred to hospital.

Consumer B

* In June 2023, Consumer B’s deterioration in health status related to diabetes was not recognised or responded to. Clinical tests that showed glucose in Consumer B’s urine which were not responded to and no further monitoring was conducted with further testing.
* The service did not respond to four falls in a month and identify the falls may be related to Consumer B’s deteriorating condition.
* Due to a high BGL reading, Consumer B was transferred to hospital where they were noted to be in a diabetic coma.

In coming to my finding for this requirement, I have also considered further evidence relating to Consumers B and D, as well as the provider’s related response, highlighted in requirements (3)(a) and (3)(d) in this Standard. Specifically, diabetes management and monitoring for Consumer B and post fall pain management for Consumer D.

The provider’s response included, but was not limited to:

* A BGL chart indicating BGLs were not required unless unwell or post fall, with the provider’s response indicating Consumer E did not become unwell until the day of transfer to hospital.
* Progress notes related to the dietitian review which do not indicate they requested BGLs to be conducted. A report from a specialist behaviour service dated August 2022 demonstrating Consumer E’s behaviours were known.
* Progress notes demonstrating Consumer E did not have any signs of deterioration, rather became acutely unwell on the day they were transferred to hospital. Progress notes in the days leading up to the episode were not provided.
* Commentary relating to two of the four falls and indicated neither of these were associated with deterioration.

I acknowledge the provider’s response. However, I find changes or deterioration in consumers’ condition were not effectively recognised or responded to in a timely manner.

In relation to Consumer E, I have considered the evidence before me which demonstrates Consumer E’s change in condition was recognised and responded to in a timely manner. Progress notes included in the provider’s response indicates appropriate actions were initiated when a change in Consumer E’s condition was recognised, which according to the supporting documentation provided, was on the day they were transferred to hospital. However, I have considered appropriate measures were not implemented to monitor Consumer E’s health and well-being, specifically in relation to diabetes, following cessation of medication. Regular monitoring of BGLs was ceased, with BGLs only indicated where Consumer E was unwell or post fall. Consumer E was transferred to hospital following a BGL reading which was too high to measure.

I have considered Consumer B’s deteriorating condition related to diabetes was not recognised and responded to in a timely manner. In the nine days prior to Consumer B being transferred to hospital following a BGL of 32.1 mmol/L, BGLs were recorded on six occasions between 12.6mmol/L to 19.9mmol/L. These readings were consistent and considerably more elevated than BGLs recorded in the 17 days prior where 10 of the 15 BGLs recorded were below 10mmol/L. There is no evidence demonstrating any action was taken in response to the elevated BGLs in the nine days prior to the transfer to hospital, including notification to the GP. I have also considered factors which may have contributed to consistently high BGLs, such as the consumer’s diabetes medication being ceased prior to entry, glucose detected in the urine and Consumer B being described as disorientated and confused were not collectively considered in response to Consumer’s B’s BGLs being consistently high in the nine days prior to being transferred to hospital.

In relation to Consumer D, I find a change in the consumer’s condition following a fall was not identified and responded to in a timely manner. Following the fall, Consumer D’s mobility was noted to decline, they displayed aggression towards staff and was groaning in pain whenever their leg was touched. Following a GP review four days post the fall, Consumer D was transferred to hospital with a suspected fracture.

For the reasons detailed above, I find requirement (3)(d) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(e)**

Requirement (3)(e) was found non-compliant following a Site Audit undertaken in March 2023 where an effective system to document and communicate a consumer’s condition, needs and preferences to enable delivery of care and services was not demonstrated. The assessment team’s report did not outline any actions implemented by the service in response to this non-compliance.

At the Assessment Contact undertaken in July 2023, the assessment team were not satisfied information regarding consumers’ condition and needs is effectively shared. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Consumers D and B did not have regular falls identified for further action at the meeting to reduce their risk.
* Pain management charts and progress notes report inconsistencies in monitoring of consumers’ pain, and pain monitoring charts do not clearly indicate consumers’ pain, or pain management needs.
* Progress notes in February 2023 note a representative was unhappy regarding a meeting they had with staff after bringing Consumer D back early after a regular outing due to an incontinent episode. Feedback sent to the service two days after the meeting indicated the representative expressed concerns relating to Consumer D’s physical state, falls and continence care.
* Consumer B’s representative said a request to management relating to recommencement of diabetes medication to be reinstated was not listened to. They said the family was reporting Consumer B was feeling sick with increased pain two days before their transfer to hospital, but staff didn’t listen because Consumer B was not telling them.
* A representative said staff hadn’t listened to the family when they said Consumer A had increased pain and needed increased care to reduce pain, They said staff said Consumer A could not see the doctor until Friday when the doctor comes. The representative said it was lucky the clinical nurse manager came to see Consumer A and contacted the doctor for pain relief.

The provider’s response included, but was not limited to:

* Individual consumer falls were discussed at handovers, with the GP and physiotherapist and risks and strategies clearly documented in related care plans. A falls prevention team was established in April 2023 and reviews falls and discusses actions required.
* Documentation relating to Consumer D’s representative’s concerns which do not indicate dissatisfaction following the discussion, and of follow-up with the representative by the service manager outlining actions implemented, including regular follow-up. Acknowledge information relating to administration of a laxative should have been given to family and have reminded staff to always consider any information that may impact on an outing.
* Progress notes to demonstrate staff reviewed Consumer B and spoke with the representative about actions being taken and indicate the representative was satisfied.
* There were no concerns regarding Consumer A’s pain management the day after the fall and family raised concerns with staff about pain once which was actioned immediately.

Based on the assessment team’s report and the provider’s response, I have come to a different view from the assessment team’s recommendation of not met and find the service compliant with this requirement. I have considered the evidence presented does not indicate systemic deficits relating to information exchange processes. In relation to feedback from Consumer D’s representative, supporting documentation included in the provider’s response demonstrates appropriate and timely action was taken in relation to the issues raised. I have also considered documentation which demonstrates individual consumer falls are discussed. However, I have considered a comprehensive review of Consumer D’s falls did not occur and have considered this evidence in my finding for requirement (3)(b) in this Standard.

In relation to incongruent information relating to pain, and feedback provided by Consumers B and A’s representatives, I have considered this information in my findings for requirements (3)(a) and (3)(b) in this Standard.

For the reasons detailed above, I find requirement (3)(e) in Standard 3 Personal care and clinical care compliant.

**In relation to requirements (3)(a), (3)(b) and (3)(d)**, I acknowledge the provider’s response included improvement actions and a PCI to remedy the deficits identified and planned completion dates have been set. However, I consider time will be required to embed these improvement actions and to establish efficacy, staff competency and improved consumer outcomes.

# Standard 7

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| Human resources | |  |
| 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. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the two specific requirements has been assessed as non-compliant. The assessment team recommended requirements (3)(b) and (3)(c) in Standard 7 Human resources not met.

**Requirement (3)(b)**

While some consumers and representatives described examples of where staff were supportive and respectful, the assessment team also received examples from consumers and representatives where they had not been treated kindly by staff. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* An Incident report for Consumer F dated March 2023 stated staff were rough with them.
* Consumer G has raised several concerns in relation to staff not being kind and caring. This included during continence care in May 2023 which caused them discomfort.
* Management told the representative staff disputed the allegations raised, the investigation did not find evidence to support the concerns raised, and the staff member continued to provide care to Consumer G and others.
* The representative said Consumer G raised concerns the week prior relating to how staff treated them, which was confirmed by Consumer G.
* Consumer G has told staff they are having trouble sleeping due to itchiness and has asked for something to relieve this. Consumer G said they have not been provided with anything and ‘staff are always saying don’t scratch.’
* A representative said staff hadn’t listened to the family when they said Consumer A had increased pain and needed increased care to reduce pain following a fall. Two staff said Consumer A always calls out and moans and it is just a behaviour why they are doing this.
* Staff did not respond to Consumer D’s changing care needs and provide pain relief following a fall. Documentation note staff recorded multiple instances of Consumer D moaning in pain and having a lot of pain overnight.
* A representative said family was reporting Consumer B was feeling sick with increased pain two days before transfer to hospital, but staff did not listen as Consumer B was not telling them.

The provider’s response included, but was not limited to:

* The incident involving Consumer F was reported to the Serious Incident Response Scheme (SIRS) and actions taken against the staff member.
* The incident in May 2023 relating to Consumer G was reported by the representative. A SIRS was submitted and an investigation undertaken. The representative was advised on the investigation outcome. At no time since the date has Consumer G or the representative advised of any further concerns.
* Progress notes demonstrating staff responded to Consumer G’s report of itchiness and actions were taken.
* There were no concerns regarding Consumer A’s pain management the day after the fall and family raised concerns with staff about pain once which was actioned immediately. While the home is not suggesting that responsive behaviours should just be accepted with no effort to understand underlying triggers, Consumer A does have a history of calling out.
* Progress notes state Consumer D was moaning in pain three days post the fall and not before, which is supported by the pain chart, included in the provider’s response.
* Progress notes to demonstrate staff reviewed Consumer B and spoke with the representative about actions being taken and indicate the representative was satisfied.

Based on the assessment team’s report and the provider’s response, I have come to a different view from the assessment team’s recommendation of not met and find the service compliant with this requirement. In coming to my finding, I have placed weight on supporting documentation included in the provider’s response which demonstrates appropriate action has been taken in relation to issues raised, specifically in relation to Consumers F and G.

In relation to Consumers A, D and B, I do not find the evidence presented demonstrates deficits relating to workforce interactions. I consider the information is more aligned to provision of consumers’ care. As such, I have considered the information in my findings for requirements (3)(a), (3)(b) and (3)(d) in Standard 3.

For the reasons detailed above, I find requirement (3)(b) in Standard 7 Human resources compliant.

**Requirement (3)(c)**

The assessment team were not satisfied personal and clinical care provided is monitored to ensure staff are delivering this in line with the organisation’s clinical governance framework, current legislation, and best practice. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Despite training and education pertaining to diabetes management following Consumer E’s diabetes incident in January 2023, staff did not demonstrate competence in providing diabetes care for Consumer B in June 2023.
* Staff did not demonstrate competence in falls management. Neurological observations were not undertaken in line with the organisation’s policy and procedure and post falls management to prevent and reduce falls was not evidenced as discussed at clinical and care meetings or implemented as recommended.
* Staff did not demonstrate competence in pain management. Documentation for two consumers evidenced information recorded in progress notes regarding pain conflicted with information recorded in pain charts. Staff did not act promptly to manage consumers’ changed needs of requiring increased pain relief.
* Staff did not demonstrate competence in identifying and responding to abuse and neglect. One consumer’s allegation of harm was not recorded as an incident or management immediately notified.

The provider’s response included, but was not limited to:

* Outlined a range of processes which routinely occur to monitor personal and clinical care provision.
* Disagree with the assertion in relation to Consumer E. Statements made in the report regarding management of Consumer E’s diabetes have been shown to be inaccurate.
* Disagree that the evidence shows incompetency in falls management; this is a documentation issue and assertions made in the assessment team’s report regarding this documentation are not always accurate. There is no requirement to discuss falls at a clinical meeting.
* The care manager advises Consumer D’s toileting schedule was checked and there was no need to change it. Half hourly sighting checks of Consumer D were implemented so they could be used to identify toileting needs.
* In relation to pain management and abuse and neglect, the provider referred to responses provided for Standard 3 requirements (3)(a) and (3)(b) and Standard 8 requirement (3)(d) which I have considered.

I acknowledge the provider’s response. However, I find the workforce was not sufficiently competent or had the knowledge to effectively perform their roles.

In coming to my finding, I have considered the outcomes for consumers highlighted in Standard 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 requirements (3)(a), (3)(b) and (3)(d), which have been found non-compliant, demonstrate consumers have not been provided care that is best practice, tailored to their needs or optimised their health and well-being, effective management of high impact or high prevalence risks or that deterioration or change in a consumer’s condition is identified and responded to in a timely manner. Deficits have been identified in provision of care relating to management of falls, pain and diabetes. As such, I find the workforce does not have the skills or knowledge they need to deliver safe and quality care and services.

I acknowledge the provider’s response included a PCI to remedy the deficits identified in this requirement and planned completion dates have been set. However, I consider time will be required to embed these improvement actions and to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

# Standard 8

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| --- | --- | --- |
| Organisational governance | |  |
| 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 |

Findings

The Quality Standard is assessed as non-compliant as the one specific requirement has been assessed as non-compliant. The assessment team recommended requirement (3)(d) in Standard 8 Organisational governance not met.

**Requirement (3)(d)**

The assessment team were not satisfied effective risk management systems and practices relating to all aspects of this requirement were demonstrated. The assessment team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Risk systems did not identify consumers experiencing pain that is being left untreated, for example, Consumers A and D.
* Staff did not manage risks associated with Consumer B’s diabetes following additional education and training relating to diabetes management or recognise changes in behaviour and high BGL readings as deterioration and act appropriately.
* The monthly number of falls have increased, however, clinical and care meeting minutes did not evidence discussion of prevention and management of consumers’ care to minimise similar incidents occurring and/or reduce incidents. The assessment team’s report referenced Consumer D’s toileting schedule not being implemented to reduced falls in February 2023, with the consumer sustaining another fall in the same month; and neurological observations not being undertaken in line with best practice or organisational policies and procedures.
* Behaviours were not managed and responded to ensure consumers receive safe and quality care to meet their changing needs. The report referenced staff stating Consumer A calling out in pain was part of their behaviour; and Consumer B’s unmanaged behaviours resulting in them being pain, not receiving diabetic care as directed, deterioration being undetected and development of high BGLs requiring transfer to hospital.
* Allegations of harm were not responded to in line with SIRS reporting obligations or with the organisation’s procedure. Three complaints raised by three consumers on two days in February 2023 noted allegations of abuse, however, only one of the complaints had been reported to SIRS. Management advised the two consumers did not provide specific examples related to their allegations and determined they did not meet the reportable incident criteria.
* Risk assessments pertaining to consumers’ choice that evidences ongoing monitoring and appropriate amendments are made if the risk has increased were not located. These included risks relating to smoking, self-medication assessment, and not being woken during the night.

The provider’s response included commentary relating to the information included in the assessment team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* Disagree there is incongruent data in Consumer D’s records relating to pain. Pain charting was being done routinely post fall at required intervals and staff were assessing Consumer D’s pain at that time.
* Provided documentation to demonstrate falls are reviewed and actions required are discussed at the falls prevention meeting established in April 2023.
* Referenced responses provided in other Standards and requirements relating to individual consumers highlighted and neurological observations which I have considered in my finding for this requirement.
* In relation to allegations of harm and abuse, it is not a case of not knowing what has to be reported, it is a case of a true belief that two of the three complaints did not meet the reporting definition. On reflection, agree that they do meet the definition. The fact that a SIRS was made for the first consumer is demonstrative of a reporting culture.

Improvement actions included:

* + Refresher education on SIRS reporting requirements for service manager and clinical care manager.
  + All complaints that include any type of allegation relating to a staff member to be reviewed by the quality manager to provide oversight of SIRS decision making for a period of six months.

I acknowledge the provider’s response. However, I find the organisation did not demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks and identifying abuse and neglect.

In coming to my finding, I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks, specifically in relation to pain and falls, including post falls management as highlighted in Standard 3 Personal care and clinical care requirement (3)(b). I have also considered that the organisation’s own monitoring processes have not identified deficits identified by the assessment team relating to management of high impact or high prevalence risks associated with consumers’ care.

In relation to identifying and responding to abuse and neglect, I have considered the service has not demonstrated a sufficient understanding and application of legislative requirements in relation to reporting. Two allegations were initially found not to meet the reporting definition. I find this has not ensured that all allegations are identified or investigated to ensure risks to consumers’ health and well-being are minimised and/or eliminated or appropriate safeguards implemented.

I have considered the evidence presented does not indicate systemic issues relating to risk management systems and practices to support consumers to live the best life they can or the organisation’s overall processes relating to managing and responding to incidents.

I acknowledge the provider’s response included improvement actions and a PCI to remedy the deficits identified in this requirement and planned completion dates have been set. However, I consider time will be required to embed these improvement actions and to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance non-compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)