Performance

Report

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| Name: | Merrimac Park Private Care |
| Commission ID: | 5746 |
| Address: | 50-52 Macadie Way, MERRIMAC, Queensland, 4226 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 18 June 2024 to 19 June 2024 |
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| Service included in this assessment: | Provider: 1659 Superior Care Group Pty Ltd  Service: 6455 Merrimac Park Private Care |

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 Merrimac Park Private Care (**the service**) has been prepared by Bruce Bassett, 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 (performance assessment) – site 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 9 July 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

* The service must ensure all consumers are treated with dignity and respect.
* Assessment and planning must involve consumers and their representatives, particularly when issues of restrictive practices are concerned.
* The service must offer consumers the opportunity to express their advanced care wishes and ensure these are appropriately documented.
* The service must ensure consumers received safe and effective personal care that is individualised, particularly in relation to behaviour management and wound care.
* The service must facilitate consumers ability to engage with the community, maintain relationships of importance and take part of activities of interest to them within the service.
* The service environment must facilitate the ability of consumers to move freely, both indoors and outdoors.
* The service must ensure that the workforce is deployed, managed and is competent to provide quality care and services, and that staff performance is regularly assessed, monitored and reviewed.
* The organisation’s governing body must promote a culture of safe, inclusive and quality care and services and be accountable for their delivery.
* The service must ensure it has effective organisation wide governance systems and clinical governance framework to support the delivery of safe, quality, care and services.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Not Compliant |

Findings

The service was found to be non-compliant in this requirement following a site audit conducted on 26 - 29 September 2023, and this related to consumers and representatives raising concerns regarding consumers identity, culture and diversity not being respected by staff.

The assessment team report indicated the service has taken actions to address the previous non-compliance including, management conducting regular spot checks during the day to observe staff and consumer interactions and reminding staff during meetings to respect consumers wishes, needs, and preferences. The management team also advised they lead by example to support staff in recognising the importance of respectful communication towards consumers.

However, during the site audit, some consumers and representatives said consumers are not always treated with dignity and respect. The assessment team report provided several examples of named consumers who raised concerns about rudeness or rough handling by staff and having to wait an unreasonably long time for staff to respond to call bells leading to episodes of incontinence and feelings of disregard. Additionally, the report included observations of the assessment team of staff members ignoring a consumer crawling on the floor and being unaware of any resources available to assist them to communicate with consumers who do not speak English.

In responding to the assessment team report, the approved provider acknowledged the deficiencies identified and stated a commitment to the enhancement and improvement of staff culture and satisfaction within the workplace.

Based on consumer feedback, care documentation records, observations, and interviews with staff and management, the service did not demonstrate consumers are respected or that their dignity is always maintained.

Following consideration of the above information, I have decided that the requirement is not compliant and therefore Standard 1 is not compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not 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. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirement 2(3)(a)

The service was found to be non-compliant in this requirement following a site audit conducted on 26 - 29 September 2023, and this related to the service being unable to demonstrate it had effective systems to ensure care plans were maintained and reviewed or that assessment, planning, and documentation for consumers subject to restrictive practices was adequate.

The assessment team report indicated the service has taken actions to address the previous non-compliance by ensuring all care plans have been reviewed and are up to date, a risk register was created to capture and focus on the highest risk consumers and provide greater oversight in relation to clinical risk and a falls audit was undertaken to ensure relevant assessments for consumers were completed.

Additionally, management advised case conferencing has increased to ensure consumers’ assessment and care planning is reflective of current needs and communication with consumers and representatives has considered each consumer’s preferred method of communication.

The service advised that as of 27 November 2023, all overdue behaviour support plans (BSPs) had been reviewed, recommendations from Dementia Services Australia had been included and that for consumers subject to a restrictive practice, informed consent was reviewed, and risk assessments and authorisations were in place. However, during the assessment contact it was identified some consumers with changing behaviours did not have a BSP in place and the assessment teams observations and discussions with the clinical management team demonstrated there continue to be consumers who are being inappropriately restrained.

Consumers and representatives said they were not satisfied the service conducts appropriate planning and assessment of consumers, and some consumers said they were not involved in effective care planning discussions.

BSPs lacked individualised and personalised strategies to support consumers and recent changes in consumers’ behaviours were sometimes absent. Staff did not demonstrate knowledge of any consumer’s documented behaviour support strategies. Staff described generalised support strategies to support consumers. For example, staff explained they provide food, fluid, toileting, and redirection in response to consumers’ changing behaviours.

The service environment includes a locked memory support unit (MSU) where 13 of 29 consumers are subject to an environmental restraint. Consumers within the unit either were not supported by staff to leave the environment alone or could not operate the coded keypad due to its location. Staff said it is not safe for consumers to exit as they lack cognitive capacity and awareness. Some named consumers who are not subject to restraint are unable to physically operate the coded keypad themselves and have to seek staff assistance if they wish to leave.

Most consumers in the main building are not subject to an environmental restraint. However, the lift has a coded keypad which not all consumers can operate. Additionally, staff said they would not allow some consumers to leave the building on their own for safety. The clinical management team said they had not conducted assessment on all consumers to determine their physical ability to use the coded keypad.

The assessment team report indicated the decision to implement a restrictive practice is not always discussed with the consumer and is often based on the wishes of the family, or the assessment from an aged care assessment team. The clinical management team said previously, information and recommendations from the hospital were implemented as provided, without representative consultation, however this practice has ceased.

Interviews with management, staff, consumers and representatives indicated a lack of understanding of what constitutes a restrictive practice, and the associated consent, assessment, and planning. Additionally, where BSPs are in place, staff were unable to articulate what strategies support a consumer’s changed behaviours.

In responding to the assessment team report, the approved provider advised an intensive and comprehensive training plan for staff is currently under development by clinical management with external training providers in areas identified for immediate improvement such as restrictive practices, including chemical and environmental restraint, and successful behaviour support planning.

Following consideration of the above information, I have determined a lack of understanding of restrictive practices is impacting upon the ability of staff to successfully complete assessment and planning for consumers. Therefore, I have decided this requirement remains not compliant.

Requirement 2(3)(b)

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023. While consumers’ care documentation generally reflected their end of life wishes and included documentation with advance care planning and statement of choices, the documentation was not maintained to reflect consumers’ current needs.

Management said the service is still ‘in a planning stage’ to rectify this deficiency and plans to review the care planning policy in relation to advance care planning. Advance care planning documents will be included in the service’s entry pack to ascertain consumers’ wishes and requirements before they enter the service.

The assessment team’s review of care documentation indicated more than 10 percent of consumers have not been involved in discussions relating to their goals and preferences around end-of-life care planning.

The service’s care planning policy outlined a requirement for advance care plans to identify a planned review date to ensure reviews of advance care plans are conducted as consumers wish or need. However, the service was unable to provide planned and recorded action dates for review of advance care planning. Care documentation demonstrated most consumers have not had their advance care plan wishes discussed for more than one year, and in some instances, multiple years.

In responding to the assessment team report, the approved provider acknowledged the deficiency in advanced care planning documentation, indicated management was aware of this prior to the assessment contact and was working to rectify the issue through a review of the care planning policy and staff training.

Following consideration of the above information, I have decided this requirement remains not compliant.

Requirement 2(3)(e)

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023, and this related to 64 care plans being overdue for review, and the service did not demonstrate consumers’ care plans were always evaluated when consumer care needs changed.

The assessment team report indicated the service has taken actions to address the previous non-compliance. The service was able to demonstrate a review of all care plans had been conducted. Management said the service has allocated a registered nurse (RN) to review care plans one day per week. Management advised this will continue to ensure consumers receive care plan reviews in accordance with their needs, goals, and preferences.

Care documentation demonstrated consumers’ care plans are being updated when changes in care needs occur. Management have increased case conferences, and plan to continue to improve their communication with consumers and representatives to ensure consumers can express their current goals, needs, and preferences.

Following consideration of the above information, I have decided that this requirement has returned to compliance.

However, as two requirements remain non-compliant, Standard 2 is not compliant.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

Requirement 3(3)(a)

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023, and this related to consumers in the MSU not receiving effective care in relation to changing behaviours and falls risks, the service being unable to demonstrate effective care systems to ensure best practice tailored care in relation to clinical care or ensure care documentation supported effective clinical care to optimise consumers’ health and well-being.

The assessment team report indicated the service has taken actions to address the previous non-compliance. For example;

* All wound care plans have been updated and consumers’ pain is being assessed at each dressing interaction. This was recorded in the service’s plan for continuous improvement (PCI) has having been completed in October 2023.
* A pain assessment audit was conducted with significant improvement in pain assessments, records and follow up notes. This was recorded as completed in October 2023.
* Training was provided to all staff on topics such as behaviour management, wound management, continence management, and legal requirements of documentation. This was recorded as completed February 2024.
* An audit of BSPs was undertaken to ensure the least restrictive options were used to manage behaviours, support positive decision making and ensure the use of pharmacological strategies is used only as a last resort. This was recorded as completed January 2024.
* Training and implementation of a new process was instituted where staff must seek authorisation from a senior clinical manager prior to the administration of any psychotropic as required medication to manage behaviour and its effectiveness must be documented and family consultation actioned. Recorded as completed January 2024.
* The clinical management team daily schedule includes follow up relating to incident management and wound management, including progress note entries, for the past 24 hours.

These actions by the service are acknowledged and are to be commended.

However, the assessment team report indicates management and staff did not demonstrate a thorough understanding of physical, environmental, or chemical restraint and were not able to demonstrate informed consent from consumers or their representatives for some consumers subjected to these types of restrictive practices. For example, while the service identified some consumers residing in the secure unit as subject to environmental restraint, it did not identify locking the front door of the unit as an environmental restraint for all consumers who could not independently operate the keypad. Additionally, the report included examples of consumers being physically restrained by staff during hygiene cares and via tight linen wrapping in bed, which were not recognised as potential restrictive practices. Management advised they were not aware this was occurring and said they would provide additional training and education to staff.

With regards to wound and pain management, all consumers sampled said their pain was well managed and evidence in the assessment team report indicated generally effective wound management. However, in 4 wound management plans, documentation indicated wound care was not completed as directed by a medical officer (MO). For example, for one named consumer requiring a dressing change 4 times a week, only 6 occasions of wound care were documented over a one-month period. For another named consumer requiring twice daily wound management, wound care was only provided once a day on 5 days in a sampled fortnight. Staff said when there is only one registered staff member on the shift, tasks are prioritised as they do not have time to complete all tasks.

In responding to the assessment team report, the approved provider advised comprehensive training for staff would be provided regarding what constitutes a restrictive practice, the relationship between psychotropic medication usage and chemical restraint, behaviour support strategies and how to document these clearly for successful reference for other staff. The response did not directly address issues identified relating to would management.

Following consideration of the above information, I am convinced staff did not demonstrate an awareness of what constitutes a restrictive practice and did not identify some consumers subject to chemical, environmental, and mechanical restraint. Additionally, wound care was not always completed as per the MO direction.

Therefore, I have decided this requirement remains not compliant.

Requirement 3(3)(b)

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023, and this related to a lack of management systems to ensure high impact, high prevalence risks and incidents were evaluated and analysed to reduce risks and improve clinical care. Staff did not demonstrate effective strategies are used to mitigate risks to consumers.

The assessment team report indicated the service has taken actions to address the previous non-compliance. Management identified the root causes of the deficiencies as a lack of clinical oversight, particularly in relation to the MSU, and a poor staff culture. The service identified staff were not acting within the service’s policies and guidelines. To address this, the service instigated daily clinical meetings and weekly clinical governance meetings which include post fall reviews and incidents as a standing agenda item. All incidents are reviewed daily and analysed monthly by clinical management staff.

Documentation around falls incidents, pain, and time sensitive medication are reviewed weekly by clinical management with daily progress note review, and quarterly audit outcomes discussed at the clinical governance meetings.

Flow charts and checklists relating to falls management were developed and placed in each wing of the service. An alert in the electronic medication system for all time critical medications was implemented and a memo went to all staff to remind them of the importance of time sensitive medication administration.

The service developed a consumer high risk register to support identification of high-risk consumers.

Training was provided to staff regarding falls and post falls management, incident management and documentation, nutrition and hydration.

Consumers said, and documentation supported, that consumers receive time sensitive medication for conditions such as Parkinson’s and diabetes as prescribed. Consumers at risk of weight loss or choking, and consumers who have experienced falls or pain said they receive the care they need, when they need it. Consumers and their representatives said staff are preventing and managing pressure injuries through skin integrity management plans which were reviewed by the assessment team.

The assessment team reviewed documentation for sampled consumers who had a history of falls. This confirmed falls management for each consumer was in accordance with the service’s falls management policy and included undertaking a head-to-toe assessment, neurological observations, and escalation to the MO or transition to hospital where required.

Staff interviewed could articulate specific strategies for consumers in relation to reducing the risk of falling and injury from falling. Staff were aware of symptoms should a time sensitive medication not be administered on time. Staff could describe the main risks to consumers and the risk mitigation strategies in place to address them.

Registered staff said they can contact or refer to a specialist if they have any concerns and will often escalate to the clinical management team for advice. Care staff said they refer to information from handover to ensure they are aware of consumers with up-to-date care needs, in line with any identified risks.

Care documentation indicated staff understand risk and are proactive in identifying and mitigating high impact and high prevalence risk, and investigation and monitoring of strategies follows incidents. Care documentation including incident reports, meeting minutes, and clinical indicator data identified a downward trend in incidents and effective monitoring and clinical oversight of care delivery for consumers.

Management explained, and minutes of meetings confirmed, weekly clinical risk meetings are held to discuss management of high-risk consumers. Topics include falls, unplanned weight loss, and pain. The service has a clinical governance framework to guide clinical oversight of high impact and high prevalence risks associated with the care of consumers.

Following consideration of the above information, I have decided that the service has returned to compliance in this requirement.

Requirement 3(3)(d)

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023, and this related to staff not recognising and responding to changes in the health status of consumers. A lack of oversight regarding clinical documentation was inhibiting the ability of staff to respond to changes in consumers’ condition.

The assessment team report indicates the service has taken actions to address the previous non-compliance. For example, all incidents and clinical changes involving consumers including infections, falls, weight loss, medication changes, pain reviews and behaviours of concern are reviewed at the clinical governance weekly meeting. Clinical management initiate follow-up for clinical concerns during their daily reviews to support timely response to observed changes in consumers.

The service developed a consumer high impact high prevalence risk register to support immediate identification of care needs. Daily review by the clinical management team is undertaken for consumers who have returned from hospital or have experienced a change of condition. Training was provided to all staff in identifying and escalating deterioration. This was recorded as being completed in January 2024.

Consumers and representatives said they are confident staff know consumers well enough to identify a change to a consumer’s health status and are comfortable to approach staff if they have concerns.

Staff said they report changes in consumers to registered staff or members of the clinical management team. If a consumer deteriorates after business hours, registered staff can telephone a MO or transfer the consumer to hospital. Care documentation indicates consumers are regularly monitored by registered staff and if deterioration or change of a consumer’s mental, cognitive, or physical function, capacity or condition occurs, this is recognised and responded to in a timely manner and representatives are notified.

The assessment team reviewed clinical and general staff meeting minutes where discussion was held about identifying deteriorating wounds, weight loss, and changing behaviours.

Care documentation reflects the identification of, and response to, deterioration or changes in consumers’ condition and registered staff explained the assessment process following changes to a consumer’s condition.

Following consideration of the above information, I have decided that the service has returned to compliance in this requirement.

Requirement 3(3)(e)

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023, and this related to the service not ensuring information about consumers’ conditions and treatment was being effectively documented and communicated within the organisation. A review of care documentation had identified gaps where recommendations from specialist services, discharge summaries and representatives had not been updated in consumer care documentation.

The assessment team report indicates the service has taken actions to address the previous non-compliance. Registered staff and clinical management are responsible for actioning recommendations from specialist services, post hospital summaries, visiting allied health services, and updating the consumers care needs documentation. The service has developed processes to ensure care is implemented as per hospital discharge summary. Medication charts are updated as required and sent through to the pharmacy for action. Weekly clinical governance meetings occur and a daily clinical management team duties schedule was developed to support the review of changes to consumer care needs.

Consumers and representatives said consumers’ care needs and preferences are effectively communicated between staff, and consumers receive the care they need.

A review of consumers’ care documentation identified correspondence from health professionals and test results to support effective and safe care, and referrals are accessible to staff and other health professionals.

Registered staff said if consumers choose to see their own MO, or attend specialist appointments, information such as pathology results, medication charts, medical history and consultation notes are provided to the consumer/representative for consultations or sent digitally if requested.

During their shift, staff use handover sheets which list any outstanding tasks or actions required, and tasks that are not completed can be handed over to the following shift. Registered staff notify the MO and representatives when a consumer experiences a change in condition, experiences a clinical incident, is transferred to, or returned from hospital, or is ordered a change in medication. Registered and care staff confirmed they receive up to date information about consumers at handover and via the electronic care management system (ECMS).

Following consideration of the above information, I have decided that the service has returned to compliance for this requirement.

However, as one requirement is not compliant, Standard 3 is not compliant.

# Standard 4

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| Services and supports for daily living | |  |
| 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. | Not Compliant |

Findings

The service was found to be non-compliant in this requirement following the site audit conducted on 26 - 29 September 2023, and this related to consumers not being provided services and supports for daily living to participate socially in doing the things of interest to them and to form personal relationships within the service environment.

The assessment team report indicates the service has planned actions to address the previous non-compliance. At the time of the site audit, the service had recruited an additional lifestyle assistant to commence employment within the following weeks to support the delivery of activities across the service. The service was also in the process of recruiting a lifestyle coordinator to support the coordination of lifestyle staff and activities across the service. Management explained once a lifestyle coordinator has been recruited, the service plans to review all consumers’ goals and preferences to ensure accurate recording of their likes, needs, and preferences to inform the delivery and support for consumers daily living.

During the site audit, consumers and representatives raised concerns about the lack of activities being conducted within the service. For example, two representatives said they were worried about a lack of activities and staff to support activities in the MSU.

The service currently has 2 lifestyle staff employed by the service. Both assistants have commenced employment within the last 2-3 months. These staff explained they were not orientated to consumers residing at the service, and were still learning consumers’ needs, goals, and preferences. Lifestyle staff explained they ask all consumers daily if they would like to attend activities, and each consumer’s response and lifestyle activity attendance is recorded in their diversional care documentation.

The assessment team report provided several examples of staff being unaware of consumers’ interests and/or care documentation not containing information regarding consumers’ interests or community engagement.

The assessment team observed a lack of lifestyle activities occurring across the service, and multiple consumers within each section of the service were observed sitting in front of a television, with limited staff interaction. Following feedback in relation to the lack of activities being conducted across the service management explained care staff are expected to conduct activities with consumers, however some fear they are not allowed to provide anything other than the provision of hygiene cares or activities of daily living.

In responding to the assessment team report, the approved provider acknowledged a current deficiency within lifestyle staffing allocations. The service has maintained a recruitment drive for the lifestyle coordinator and lifestyle assistant positions. The response expressed a commitment to deliver appropriate activities across all areas of the service including the MSU seven days a week. New lifestyle programs will be developed by the new staff in coordination with consumers and representatives and the centre manager. The response indicates an expectation of significant improvements in this regard by the end of August 2024.

Based on consumer and representative feedback, recorded care documentation, observations, and staff and management interviews regarding a lack of activities and a low level of staff knowledge and documentation regarding consumer lifestyle preferences, I have decided this requirement continues to be not compliant.

As this requirement is not compliant, Standard 4 is not compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not Compliant |

Findings

Requirement 5(3)(a)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to the service’s MSU environment being unwelcoming with descriptions of malodour and a lack of spaces to encourage independence and interaction.

The assessment team report indicates the service has taken actions to address the previous non-compliance. These included reconfiguring the design of the MSU, providing artwork and refurbished areas, reviewing the disposal of continence aides and cleaning schedules to address the malodour for the MSU areas of the service and revising the staff rostering to support a higher delivery of care and services for the consumers in the MSU and enable staff to have time within their workload to offer the consumers physical assistance to further enjoy their environment and the areas available to them.

Consumers and representatives said they felt the service is welcoming and generally gave positive feedback regarding the overall environment, including providing comments of improvements at the service in this regard.

The service provided evidence the MSU environment had been considered and adapted to support consumer needs. Areas are free from clutter and staff discussed individual consumer’s requirements for space to enable them free movement or maximising their safety.

The assessment team observed;

* + Consumers rooms are decorated with furnishings and personal items which reflect individual tastes and styles.
  + The environment to be clean and with minimal malodour.
  + Artwork and furniture contributing to a functional environment.
  + Consumers spending time relaxing or otherwise interacting with their family or friends in several areas throughout the service.

The service has wide corridors, outdoor areas where consumers can meet with friends and family, and large indoor communal areas. There is ample natural light, and the environment appeared safe and is clean. The service was observed to be welcoming and easy to navigate.

Following consideration of the above information, I have decided that this requirement has returned to compliance.

Requirement 5(3)(b)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to consumers in the MSU not being able to move freely around the service or have access to outdoor areas. Staff said consumers were unable to leave the MSU area as there were not enough staff to monitor their movements.

The assessment team report noted that landscape improvements have been resourced to support a more dementia friendly environment and the service was able to demonstrate the environment is safe, clean, and well maintained. The assessment team observed the service interior to be free from clutter and any fire exit or equipment obstruction, and the external landscape to be well maintained, free from trip hazards and suited to differing levels of mobility.

Consumers and representatives said they felt safe and comfortable at the service and gave positive feedback regarding cleaning and maintenance.

Internal and external doors (to the secure garden) have been opened to support movement around the unit. However, during the assessment contact the assessment team observed the doors for consumers to access outdoors areas were locked on a rotational basis and consumers were unable to move freely around the service environment; indoors and outdoors.

The service’s main building has 2 levels; the second level accessible by a lift with a 4-digit coded keypad to provide access from the second to ground level (and exit the building). The 4-digit code is displayed beside the keypad, however, staff said not all consumers have capacity to use the keypad and operate the lift, so staff provide assistance.

Following feedback from the assessment team, management acknowledged the practice of locking doors to outdoor areas should not occur, and said it was unclear if all consumers have a current capacity assessment to operate the lift keypad.

The approved providers response did not address the deficiencies identified for this requirement.

Following consideration of the above information, I have decided the requirement remains not compliant as consumers were unable to move freely within the service, both indoors and outdoors and were not enabled to do so by the service.

As one requirement remains not compliant, Standard 5 is not compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Not 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

Requirement 7(3)(a)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to insufficient staff levels in the MSU resulting in adverse impacts on consumer care. For example, clinical care staff did not have enough time to complete their work, and consumers were not able to access the outdoor area as there was not enough staff to supervise them.

The assessment team report indicated the service has taken actions to address the previous non-compliance. The service reviewed and increased roster and staff allocations in both the MSU units with increased staffing on both morning and afternoon shifts in each unit, and an increase to both an enrolled nurse and a RN on each morning and afternoon to share the registered staff responsibilities.

Consumers and representatives provided mixed feedback regarding the adequacy of staffing at the service. Consumers with lower care needs said they were generally satisfied their needs are met by staff at the service. However, several consumers and representatives provided examples of how staff numbers or the staff range of skills did not meet the consumers’ needs and/or deliver safe and quality care, referencing for example, consumers waiting long periods for staff to respond to calls for assistance. The assessment team observed call bell waiting times over 10 minutes during the assessment contact. Two representatives said there ‘is nothing to do’ for the consumers in the MSU, and explained they felt there was not enough lifestyle staff to facilitate activities.

The clinical management team explained they have identified staff who consistently underperform and do not meet requirements of their job roles, however, management explained ‘we don’t have the time’ to performance manage them as one member of the clinical management team recently resigned.

Management advised that although the service is not meeting mandatory care minutes (due to recent additional consumers entering the service) and mandatory RN minutes are marginally under the requirement, the service has several new staff appointments underway.

In responding to the assessment team report, the approved provider indicated that recruitment of competent registered nursing staff is continuing, and the service will be addressing high risk non-compliances which relate directly to quality of care immediately. The service is recruiting new personnel to strengthen the clinical and quality compliance monitoring team and provide additional mentoring, training and support to staff. The service is also actively pursuing a staff recognition program to assist and improve the staff culture within the service. I acknowledge the plans of the approved provider to address the deficiencies identified during the assessment contact.

Following consideration of the above information, I concluded the service was unable to demonstrate the deployment and management of staff enabled safe and quality care for consumers. Therefore, I have decided that this requirement remains not compliant.

Requirement 7(3)(c)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to staff lacking the knowledge required to perform their roles and care documentation not being completed to the degree of competence required. Staff did not have a common understanding of restrictive practices or the falls management process.

The assessment team report indicated the service has taken actions to address the previous non-compliance, including conducting staff training throughout the service for all staff in a variety of delivery platforms, re-developing the staff education and training matrix and developing registered staff mandatory training sessions.

Feedback from consumers and representatives and some of the workforce identified they felt the workforce was not competent or do not have the knowledge to deliver care and services to meet the needs and preferences of consumers. For example, some consumers said they experienced indignity or rough handling during the provision of cares.

The assessment team observed that some staff do not have the knowledge to effectively perform their role, including staff inappropriately handling a consumer. The report also found behaviour support planning to be insufficiently completed for several consumers and staff interviewed did not have a shared understanding of restrictive practices.

Management said staff competencies are determined depending on the staff member’s role and are outlined in the relevant position description. Staff competence is monitored through a variety of ways including consumer/representative and staff feedback, benchmarking surveys, and the National Aged Care Mandatory Quality Indicator Program data.

Management said the service has commenced recruitment of a lifestyle coordinator and in response to the assessment team feedback, said they would investigate reports of staff behaviour and instances of unregulated restrictive practices.

In responding to the assessment team report, the approved provider advised they were committed to the enhancement and improvement of staff culture and satisfaction within the workplace.

Following consideration of the above information, which includes statements from consumers and representatives that some staff lack competence or knowledge to deliver care and services, I have decided this requirement remains not compliant

Requirement 7(3)(e)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to the service being unable to demonstrate regular assessment, monitoring, or reviewing of staff performance.

The assessment team report indicated the service has taken actions to address the previous non-compliance. The service included staff performance appraisals on the human resource compliance matrix to support a manageable approach to completing staff performance appraisals, and planned to complete staff performance appraisals due.

The service was able to demonstrate that staff have annual performance appraisals, however staff are not being effectively monitored and performance managed to maintain the workforce’s overall ability to provide safe and quality care and services.

Staff confirmed they have had a performance appraisal, and said they feel supported by management when they provide feedback, or request training. Staff also said they can provide feedback or concerns about other staff performance to peers or management.

Management said, and the assessment team observed, evidence of staff performance appraisals. All staff have had a performance appraisal within previous 12 months, excepting those currently on leave.

Management said it collects feedback on staff performance from multiple sources, for example, staff feedback and forms (which allow for anonymity), consumer feedback and peer supervision. There is a performance management process which includes adhering to the relevant position description as necessary.

However, the clinical management team said while they have identified staff who consistently underperform and do not meet requirements of their job roles, they do not have time or resources to allocate to performance management.

Management was unaware staff had treated consumers in an undignified way, had inappropriately manually handled consumers, and did not have a shared understanding of restrictive practice.

In responding to the assessment team report, the approved provider advised that strengthening of the clinical and quality compliance monitoring team will improve monitoring and auditing of staff performance and increase the transparency of information received by the executive team.

Following consideration of the above information, I have decided this requirement remains not compliant. As 3 requirements are not complaint, Standard 7 is not compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Not 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. | Not 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. | Compliant |
| 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  (iii) open disclosure. | Not Compliant |

Findings

Requirement 8(3)(b)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to the service’s ECMS not being used to support staff or management in identifying, responding to, or reporting on information of importance. The incident management system was not identifying incidents reportable under Serious Incident Response Scheme (SIRS). Operational reports failed to inform the service’s governing body of the inadequacy of staffing and a clinical audit conducted once per year did not support continuous monitoring of the performance of the service.

The assessment team report indicated the service has taken actions to address the previous non-compliance. All staff were provided training in the ECMS, and service worked with the ECMS provider to better format reports, so the service is better able to analyse data around staffing and include these in Board meetings. The service introduced weekly incident monitoring by the clinical management team onsite and retraining of RNs in reportable incidents and the SIRS. The service has employed a quality assurance nurse to undertake internal audits and engaged an external organisation to review audits quarterly and provide reports to the Board.

Some consumers and representatives said they were concerned about raising issues with the assessment team because of the possibility of repercussions if they were identified. They said their concerns were around staff more than the management team, though management was also included at times. Management said there may be historical concern due to the response to concerns of the previous management team.

Some consumers said they felt they were not treated in a way which was safe and inclusive, referencing their cares being delivered in a rough and disrespectful way.

As staff do not have a clear understand of restrictive practices, consumers are being inappropriately restrained which does not support health, safety, and well-being.

In response to the assessment team report, the approved provider advised the service has purchased and is implementing a new high quality risk management system to be commenced in August 2024. The response indicated the system will provide real time notifications and reporting to specified members of the service management team and the executive management team, which will allow improved oversight and increased accountability for management and the governing body.

Based on consumer feedback, care documentation records, observations, and interviews with staff and management, the service was unable to demonstrate the Board is effectively promoting care and services which are safe and inclusive. I have therefore decided this requirement continues to be not compliant.

Requirement 8(3)(c)

The service was found to be non-compliant in this requirement following the Site Audit conducted from 26 to 29 September 2023, and this related to the following:

* Ineffective organisation wide governance systems in relation to information management, continuous improvement, workforce governance and regulatory compliance.
* Information to guide staff practice relating to care plans and BSPs was not accurate as plans had not all been reviewed for currency and accuracy.
* Information management systems were ineffective with respect to staffing issues, incident reporting, and policies and procedures.
* The continuous improvement system was not used effectively to document, monitor, and evaluate improvements.
* Workforce governance systems did not monitor or respond to staffing insufficiencies effectively. The number and skill mix of staff was not effectively planned to enable the safe delivery of care and services.
* The service could not demonstrate effective monitoring of regulatory responsibilities was occurring at the service level in relation to the SIRS reporting obligations or in relation to restrictive practices and their responsibilities.

The assessment team report indicated the service has taken the following actions to address the previous non-compliance.

* As of 27 November 2023, all overdue BSPs had been reviewed and recommendations from Dementia Services Australia had been included. However, during the assessment contact, care documentation review evidenced some consumers with changing behaviours did not have a BSP in place.
* The service undertook a review of information systems to create better reports and policies and procedures were reviewed, though the assessment team report indicated some policies and procedures were still lacking detail to assist with reporting of incidents.
* A new PCI was developed to record actions planned and implemented to facilitate the service’s return to compliance. This was recorded as being completed in April 2024. The service has created another PCI to record and measure future continuous improvement activities.
* The service undertook a review of all incidents identified as reportable incidents which had not been included in mandatory reporting, with these being reported outside of reporting timeframes.
* Staff have undertaken education and training with a focus on chemical restraint, but during the assessment contact it was evident that staff still do not have full understanding of the other types of restraint being used at the service. The service is working with the Commission’s Restrictive Practices Unit to receive further training.

The assessment team report indicates the service has some effective governance systems relating to continuous improvement, and financial governance. However, there are identified deficiencies in information management, regulatory compliance, workforce governance and feedback and complaint systems.

Information management

Consumers and representatives said the service has monthly meetings where they are updated on what is happening with the service and can raise concerns they have.

Most staff said they can access the ECMS and undertake handovers at the start of their shifts, however new and agency staff said they can struggle to use the ECMS, and handovers were not being held as a collective group which meant information was not always handed over to all staff. Following feedback from the assessment team, management explained the handover process was being reviewed after staff feedback had identified the same deficiencies.

Continuous improvement

The assessment team reviewed the service’s PCI which identified initiatives are drawn from a variety of sources, including consumer and representative feedback and complaints mechanisms. While the service’s PCI recorded remedial actions for deficiencies identified during the site audit in September 2023 as being completed, the ongoing deficiencies noted in this report indicate a failure to evaluate and/or monitor the remedial actions for their effectiveness. The service updated its PCI while the assessment team was onsite to reflect the feedback given by the Assessment Team.

Financial governance

Management stated they do not have a strict budget and can approach the Board for increased expenditure as needed, if there is an identified need to improve the consumers care or services. A member of the Board said they recently identified a need for a new position to be created and this position has recently been filled to assist the provider to better monitor its governance.

Workforce governance

Management said they plan the workforce to ensure there are sufficient staff to provide services and to support operational and administrative functions, however, the service is currently not fully meeting its care minutes on an ongoing basis. Staff stated they can be rushed when providing care and at times will need to hand over tasks to the oncoming shift.

Regulatory compliance

The service was able to demonstrate it is meeting its reporting requirements for the SIRS. Staff demonstrated a shared understanding of reportable incidents. Registered staff could describe the process for escalating and reporting incidents. Management said they reviewed their incident register and completed reporting for those incidents which had been missed, even those outside of their reporting timeframes. The service was, however, unable to demonstrate a shared understanding of restrictive practices amongst all staff.

Feedback and complaints

The organisation has a complaints and feedback system in place, however, some consumers and representatives raised concerns around retribution from staff and management if they were identified as providing feedback to the assessment team when interviewed. Following feedback from the assessment team, management acknowledged there were some issues with previous management not handling complaints and feedback in a positive way.

In response to the assessment team report, the approved provider advised that the reluctance of some consumers and their representatives to bring forward concerns due to a fear of retribution was of significant concern to the organisation. The service’s centre manager has issued a written notification to consumers and representatives outlining the importance of bringing concerns forward and reassuring them these will always be treated with privacy and respect. Open consumer and representative meetings will be offered twice a month from July with the offering of information and feedback on complaints and compliments.

Following consideration of the above information, I have decided this requirement remains not complaint as staff indicated difficulties in navigating the service’s ECMS, continuous improvement actions did not appear to have been evaluated, staff lacked a shared understanding of restrictive practices and consumers and representatives feared to provide feedback citing concerns of retribution.

Requirement 8(3)(d)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to the service being unable to demonstrate an effective risk management system. Reporting of incidents was not consistent, and incidents appeared not to have been investigated or evaluated to prevent further incidents.

The assessment team report indicated the service has taken actions to address the previous non-compliance. Daily clinical meetings and weekly clinical governance meetings include post fall reviews and incidents as a standing agenda item. All incidents are reviewed daily and analysed monthly by clinical management. A full audit of all falls is checked against risk and pain assessments by clinical management and daily progress notes are reviewed to ensure appropriate follow up and documentation.

The service has developed effective risk management systems and associated practices. These systems identify and manage high-prevalence and high-impact risks, including abuse and neglect. The service has developed clinical governance framework to monitor clinical indicators and incidents, as well as set out roles and responsibilities.

The service has an incident management system, which demonstrates incidents are recorded, contributing factors are identified and follow up actions implemented. Management advised incidents are reviewed, risks and risk mitigation strategies are identified and implemented.

Staff are provided with relevant training, in for example, incident management and reporting, falls minimisation, challenging behaviours, fire and emergencies, preventing and managing pressure injuries and infection control. Staff stated they are reporting incidents and have received training in incident reporting.

Following consideration of the above information, I have decided that this requirement has returned to compliance.

Requirement 8(3)(e)

The service was found to be non-compliant in this requirement following the site audit conducted from 26 to 29 September 2023, and this related to consumers experiencing pain and falls not being adequately assessed in a timely manner. Neurological observations were often not completed for consumers who suffered falls as per the service’s falls management policy.

Additionally, a review of consumers’ care documentation evidenced chemical restraint was sometimes used as a first response to managing consumer’s behaviour and did not demonstrate attempts to minimise the use of chemical restraint.

The assessment team report indicated the service has taken actions to address the previous non-compliance. Management reviewed all policies and procedures of the service including falls and pain management. Registered staff at the service undertook a 4-day training program which included pain and falls management as well as review of the use of chemical restraints and the use of chemical restraint can only be authorised by clinical management and staff are regularly reminded to document all nonpharmacological interventions.

The service has a clinical governance framework and associated policies and processes to guide the delivery of clinical care which includes policies on anti-microbial stewardship, and this is practiced.

Consumer and representatives gave examples of open disclosure in practice with management and clinical staff demonstrating an understanding of open disclosure.

Whilst the service has undertaken training and education around chemical restraint to reduce its use as a first line strategy, and this has been effective, staff are still lacking a common understanding of restrictive practices in general with staff subjecting consumers to environmental and mechanical restraint without the appropriate consent, assessment, or planning.

In responding to the assessment team report, the approved provider expressed a commitment to strengthening clinical governance within the service, identifying actions such as employment of new quality monitoring personnel, the implementation of a new electronic risk management system, increased intensive training for staff and improved executive reporting and oversight.

Following consideration of the above information, I have decided this requirement remains not compliant as the service could not demonstrate staff have a common understanding of restrictive practices and minimising their use.

As 3 requirements are not compliant, Standard 8 is not 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)