

**Performance Report**

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| Name: | Merrimac Park Private Care |
| Commission ID: | 5746 |
| Address: | 50-52 Macadie Way, MERRIMAC, Queensland, 4226 |
| Activity type: | Review Audit |
| Activity date: | 11 November 2024 to 15 November 2024 |
| Performance report date: | 17 December 2024 |
| 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 P. Sherin, 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 Review audit 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 December 2024 providing additional information.
* The assessment team’s report for the assessment contact conducted 18 -19 June 2024 and the performance report dated 23 July 2024.
* the monitoring reports for the monitoring assessment contacts conducted 23 - 24 April 2024 and 27 November 2023.
* the assessment team’s report for the Site audit conducted 26 - 29 September 2023 and the performance report dated 13 November 2023.
* The assessment team’s report for the assessment contact conducted 14 - 15 June 2023 and the performance report dated 6 July 2023.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 2(3)(a): ensure completion of behaviour assessments and individualised behaviour support plans for consumers.
* Requirement 2(3)(b): ensure completion of advance care planning for consumers.
* Requirement 2(3)(e): implement oversight and monitoring processes to ensure effective and regular review of care and services occurs.
* Requirement 3(3)(a): implement improvement actions to ensure the provision of safe and effective clinical care.
* Requirement 3(3)(b): implement effective clinical monitoring systems and processes for the management of high-impact and high-prevalence risks to consumers.
* Requirement 3(3)(c): implement staff training and establish oversight processes to ensure effective pain management for consumers at end of life.
* Requirement 3(3)(d): implement improvements to ensure timely identification and response to deterioration and changes in consumers’ health and condition.
* Requirement 4(3)(c): provide lifestyle staff training and implement a lifestyle activities schedule catering to consumers’ diverse needs and interests.
* Requirement 7(3)(d): ensure registered staff and lifestyle staff are appropriately trained, equipped, and supported to deliver outcomes under the Quality Standards.
* Requirement 8(3)(c): ensure effective organisation-wide governance systems and practices for continuous improvement, workforce governance, and regulatory compliance.
* Requirement 8(3)(d): implement improvements to ensure effective management of high-impact and high-prevalence risks and consistent serious incident reporting.
* Requirement 8(3)(e): implement effective systems, processes, and improvements to strengthen clinical governance at the service.

# Standard 1

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

Findings

**Requirement 1(3)(a)**

Consumers and representatives said staff treat consumers with dignity and respect, and their identity, culture, and diversity are valued. Care planning documentation provided information on individual consumers’ background and how they wish their diversity to be supported. Staff spoke of consumers with respect and demonstrated knowledge of individual consumers’ background and preferences. Staff are provided training during orientation and ongoing education on consumer dignity and respect.

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically in relation to excessive wait times for staff assistance with personal and hygiene care resulting in incontinence and lack of dignity for consumers. The service evidenced the following actions taken to remediate the deficiencies:

* Engagement of additional staff on each residential floor as a ‘float person,’ to work between residential wings, responding to consumers’ personal and hygiene requests in a timely manner.
* Completion of staff training and knowledge testing on consumer dignity and choice. Toolbox training provided to staff on ensuring timely assistance with personal and hygiene care.
* Initiation of random spot checks prior to commencement of morning shifts to ensure consumers have received personal and hygiene care.
* Monthly review of feedback, complaints, and call bell response times to identify any concerns.

Based on the information above, and the positive feedback received from consumers and representatives, I find this Requirement compliant.

**I find all other Requirements within this Standard compliant as:**

Consumers and representatives said care and services provided are culturally safe. Staff demonstrated knowledge of individual consumers’ cultural background and described how they provide care and services in line with individual cultural needs and preferences. This aligned with information captured under care documentation to guide staff practice. Whilst the service celebrates cultural days as part of its lifestyle calendar, some consumers provided feedback regarding lack of cultural activities and events at the service. This information has been considered under Requirement 4(3)(c).

Consumers and representatives said staff consult with them about decisions regarding the consumer’s care and services and consumers are supported to maintain relationships important to them. Staff described how consumers are supported to exercise choice and independence and to communicate their preferences. Staff demonstrated knowledge of relationships of importance to individual consumers in line with information captured under care planning documentation.

Consumers and representatives said the service supports consumers to engage in activities that may pose a risk to the consumer. Staff demonstrated knowledge of individual consumers who have chosen to engage in activities of risk to them and strategies in place to ensure their safety. Review of documentation identified risk assessments are conducted and a discussion regarding potential risk of harm occurs with the consumer and/or representative captured within signed dignity of risk forms. The service has policies and procedures to guide staff in supporting consumers to take risks.

Consumers and representatives said the service provides information which is clear and easy to understand and enables informed decision-making. Review of documentation evidenced, and staff described, information is provided to consumers in various ways. Information regarding service improvements, feedback and complaints, and other matters is shared via consumer/representative meetings and food focus group meetings. Care documentation captures information on consumers’ preferred mode of communication. A variety of information was observed accessible to consumers throughout the service.

Consumers and representatives said staff respect consumers’ privacy and they have confidence in the service maintaining the confidentiality of consumers’ personal information. Staff described practical ways used to ensure consumer privacy when providing care. The service has policies and procedures to guide staff in the collection, use, sharing, and storing of personal information. Staff were observed maintaining consumer privacy and confidentiality. Where a consumer evacuation list was identified displayed in 2 locations publicly accessible, this was rectified by management on feedback.

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

Findings

This Quality Standard is non-compliant as 3 of 5 Requirements have been found non-compliant. The non-compliance relates to the following:

* Lack of individualised behaviour support plans.
* Lack of advance care planning and end-of-life planning for consumers.
* Not demonstrating satisfactory processes to ensure effective and regular review of care and services occurs.

I have made this decision based on the following analysis.

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

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18-19 June 2024. The non-compliance was specifically in relation to lack of systems to identify consumers subject to restrictive practice and ensure appropriate documentation; lack of individualised behaviour support plans; and issues of environmental restraint in relation to consumers’ access to a coded keypad to use an elevator and access to a secure outdoor area within the memory support unit. The service has implemented improvement actions such as establishing a restrictive practice register, providing staff training on restrictive practices, and completing an audit to identify outstanding behaviour support plans. Issues related to environmental restraint have been rectified as outlined under Requirement 5(3)(b).

However, the Review audit report identified most behaviour support plans are not individualised or are incomplete, and the restrictive practice register has not been kept up to date.

The Review audit report additionally provided the example of 3 consumers to evidence the service did not demonstrate systems to identify other areas of risks outside of assessment and planning processes and to incorporate strategies to minimise risk. I have not placed weight on this information given the lack of actual or potential impact to the named consumers and based on the Provider’s response capturing appropriate actions taken to address this.

The Provider has not refuted the findings and has advised of planned improvements to remediate the deficiencies. This includes, but is not limited to, conducting behaviour assessments for consumers, staff training, and completion of individualised behaviour support plans by March 2025.

Having considered the Review audit report and the Provider’s response, I find deficiencies in behaviour assessments and support plans remain ongoing. Improvement actions have not been fully implemented or evaluated for effectiveness.

I, therefore, find this Requirement non-compliant.

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

The Review audit report identified whilst assessments are completed when consumers commence at the service and periodically thereafter, advance care planning and end-of-life planning does not occur. Consumers and representatives could not recall discussions with the service relating to consumers’ end-of-life wishes. Clinical management confirmed advance care planning discussions have not occurred with consumers, other than upon entry to the service. Care documentation did not evidence consistent updates to reflect consumers’ current needs, goals, and preferences regarding advance care and end-of-life.

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically in relation to lack of documentation and review of advance care and end-of-life planning. The service has updated the advance care planning policy to specify annual reviews, included this as a task on its care plan review checklist, and completed an audit to identify over 30 consumers did not have documented end-of-life wishes. However, consumers’ advance care planning remains outstanding despite being listed as an open improvement action on the service’s continuous improvement plan.

The Provider acknowledged the deficiencies and advised of planned improvements such as implementing a review schedule and monthly audits to ensure advance health directives and statement of choices are in place for consumers. Expected completion of improvement actions is March 2025.

Having considered the Review audit report and the Provider’s response, I find deficiencies remain. Lack of advance care planning remains an ongoing issue as the service has not effectively taken action to rectify this.

I, therefore, find this Requirement non-compliant.

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

The Review audit report identified processes are in place to ensure regular review of consumers’ care documentation 3-monthly, including when circumstances change, or incidents occur. A care plan review schedule is established. However, whilst care documentation identified regular review had occurred, several examples were brought forward to evidence the service’s review processes have been ineffective as they have not identified gaps in care planning documentation and/or resulted in an update to information where the consumer’s needs and condition had changed. This included:

* For one consumer recommended by the medical officer to be commenced on a palliative care pathway, this information was not reflected under their care plan until nearly 2 months following the recommendation.
* For one consumer recommended by a dietitian in March 2024 to be commenced on dietary supplements due to ongoing unplanned weight loss, the addition of the supplement was not documented within their care plan and included under charting.
* Inconsistencies in information recorded in care documentation regarding suprapubic catheter management for one consumer.
* No review or actions taken following an increase in changed behaviours of verbal and physical aggression for one consumer.
* Several consumers were noted to have significant changes in weight incorrectly charted which had not been identified under the service’s review processes.
* Review of behaviour support plans for effectiveness or a discussion on advance care planning as part of ongoing care plan reviews where required, had not occurred.

The Provider’s response acknowledged the findings and advised of immediate corrective actions taken to address the gaps in documentation for named consumers. The Provider further advised the service’s assessment and care planning policy would be updated to provide clear guidelines, tools, and checklists on care plan reviews by end of January 2025. Following this, monthly audits will commence, and registered staff will receive training on care plan review processes.

Having considered the Review audit report and the Provider’s response, I find the service has not demonstrated satisfactory processes at present to ensure an effective review of care and services occurs for consumers. Improvement actions have yet to be implemented, will require time to be embedded within the service, and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

**I find the remaining Requirements within this Standard compliant as:**

Consumers and representatives expressed satisfaction with their involvement in assessment and planning. Registered staff and clinical management described how they involve consumers and representatives in assessment and planning and consult with other health specialists based on the consumer’s needs. Care planning documentation recorded when discussions with consumers/representatives have occurred and evidenced the involvement of other health professionals. Whilst some gaps and inconsistencies were identified in documentation of recommendations from allied health professionals under care plans, this information has been considered under Requirements 2(3)(e) and 3(3)(b).

Consumers and representatives said communication from the service is appropriate, they are kept well informed and can access care plans. Clinical management and registered staff said they have access to care plans via the electronic care management system, and described how the outcomes of assessment and planning are communicated to consumers and representatives.

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

Findings

This Quality Standard is non-compliant as 4 of 7 Requirements have been found non-compliant. The non-compliance relates to the following:

* Not demonstrating provision of safe and effective clinical care to consumers.
* Ineffective systems and processes to ensure the management of high-impact and high-prevalence risks to consumers.
* Not demonstrating effective pain management to maximise consumers’ comfort at end of life.
* Not ensuring timely identification and response to deterioration or changes in consumers’ health and condition.

I have made this decision based on the following analysis.

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

The service was previously found non-compliant in this Requirement under an assessment contact dated 14 -15 June 2023, a Site audit dated 26 - 29 September 2023, and an assessment contact dated 18 -19 June 2024. The non-compliance related to various matters including, lack of effective wound care, inconsistent post-fall neurological observations, and ineffective management of restrictive practices and changed behaviours.

The Review audit report identified:

* Some consumers/representatives expressed dissatisfaction with clinical care.
* For one consumer with complex care needs requiring use of a percutaneous endoscopic gastrostomy (PEG) tube for nutritional intake, review of documentation evidenced the consumer had not been provided nutritional supplements consistently in line with dietitian’s recommendations. Fluid intake was inconsistently recorded, the consumer’s weight incorrectly charted, and concerns identified regarding lack of agency staff knowledge of PEG management and enteral feeding.
* For 3 consumers, appropriate wound care was not provided as per the consumers’ wound care management plans, and/or pressure area care and repositioning did not regularly occur to support skin integrity.
* Staff demonstrated good knowledge of restrictive practices. Appropriate authorisation/consent forms were in place for consumers subject to a restraint. However, individualised behaviour support plans are incomplete, and the service’s restrictive practices register is not up to date as outlined under Requirement 2(3)(a).
* Post-fall neurological observations remain inconsistent as outlined under Requirement 3(3)(b).
* Whilst training has been provided to staff on wound care and restrictive practices, other improvement actions in relation to wound management and restrictive practices have either not been completed or not evaluated for effectiveness. An internal audit schedule has not been established, regular wound care audits are not occurring, and clinical monitoring processes are yet to be fully implemented.

The Provider’s response includes information on immediate corrective actions taken to address concerns identified for named consumers in the Review audit report. The Provider further advised of planned improvements including but not limited to staff education and training, competency assessments, allocated time for Clinical nurses to review consumers with complex care needs, and commencement of monthly audits. Improvements are expected to be completed between end of January – February 2025.

Having considered the Review audit report and the Provider’s response, I find the service continues to fail to demonstrate consumers receive safe and effective clinical care, which is best practice, tailored to their needs, and optimises their health and wellbeing. Deficits in wound care, restrictive practices, and post-fall management remain ongoing. The service’s clinical monitoring processes have not been fully implemented to ensure consumers receive safe and effective clinical care.

I, therefore, find this Requirement non-complaint.

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

The Review audit report identified some consumers and representatives expressed concerns regarding lack of risk management for individual consumers. Review of documentation identified deficiencies in the management of high-impact and high-prevalence risks such as unplanned weight loss, administration of time-sensitive medication, post-falls management, and changed behaviours. This included:

* For 2 consumers with changed behaviours including verbal and physical aggression, sexually inappropriate behaviour, and resistance to personal care, staff were not aware of strategies to manage their behaviours. Incidents had not been reviewed to identify reasons for escalating behaviours and effectiveness of behaviour management strategies.
* For 5 consumers requiring time-sensitive medication, these had not been administered within recommended timeframes.
* For 3 consumers experiencing unplanned weight loss, review of documentation identified incorrect and inconsistent food/fluid/nutritional supplement charting, incorrect recording of weight, and lack of review to ensure specialist recommendations were being effectively implemented.
* For 2 consumers who experienced unwitnessed falls, neurological observations were not completed on occasion in line with the service’s requirements.
* Clinical management said they were having to do the work of registered staff preventing effective oversight and management of risks. This information has been considered within the context of appropriate training and support for registered staff under Requirement 7(3)(d), and workforce and clinical governance under Requirements 8(3)(c) and 8(3)(e).

The Provider has acknowledged the deficiencies and provided information on immediate corrective actions taken to address concerns for the named consumers. The Provider has additionally advised of comprehensive improvements planned and underway, expected to be completed by April 2025.

I acknowledge the Provider’s ongoing efforts to strengthen risk management at the service via extensive staff training and education, ensuring monthly clinical trending and analyses, and conducting fortnightly clinical meetings to discuss high risk consumers. However, these have not resulted in remediating deficiencies.

Having considered the Review audit report and the Provider’s response, I find consumers remain exposed to risk as the service has not demonstrated active and effective clinical oversight and monitoring systems and processes to manage high-impact and high-prevalence risks to consumers.

In forming my view, I have also taken into consideration that the service had only recently returned to compliance in this Requirement under the performance assessment conducted 18 –19 June 2024. Previously identified deficiencies have reoccurred, and improvement actions have not been sustainable. Further improvements will require time to be embedded within the service’s processes and testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

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

The Review audit report identified the service did not demonstrate effective end- of-life care delivery for consumers, specifically in relation to ensuring their comfort is maximised through appropriate pain management. This included:

* For one consumer on an end-of-life pathway, care documentation did not evidence pain was assessed hourly in line with medical officer recommendations or that pain was effectively managed through timely administration of pain relief. Whilst the consumer’s representative was satisfied with pain management and comfort care provided, clinical management expressed concerns regarding the reluctance of registered staff to administer pain relief.
* Care documentation for one consumer who passed away at the service in November 2024 identified their pain was not regularly assessed. The consumer had a maggot-infested wound on their face (which had not been reported as a serious incident) and was charted to receive pain medication via a syringe driver. Clinical management said, and review of documentation identified, the palliative care team reported non-verbal signs of pain and sufficient pain medication not being administered particularly at night, requesting registered staff administer this more frequently.
* Registered staff did not demonstrate a shared understanding of how to manage pain and maximise consumers’ comfort when nearing end of life.
* Completion of advance care and end-of-life planning for consumers remains outstanding as identified under Requirement 2(3)(b).

The Provider’s response acknowledges registered staff did not demonstrate knowledge of how to manage consumers’ pain at end of life. The Provider advised of planned improvements to address this such as staff training and completion of advance care planning for consumers. Expected completion date for these actions is April 2025. I have no information before me to demonstrate how the Provider plans to ensure consumers receive safe and effective pain management in the interim.

Having considered the Review audit report and the Provider’s response, I find deficiencies remain. Improvements are yet to be implemented and consumers currently palliating or at end of life remain at risk of not having their pain assessed and managed effectively.

I, therefore, find this Requirement non-compliant.

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

The Review audit report brought forward information identifying the service had not effectively identified and/or responded to deterioration or changes in the health and condition of some consumers. This included:

* The representatives of 3 consumers expressed dissatisfaction with the service not identifying factors contributing to changes and deterioration in the consumer’s condition, including unplanned weight loss, escalating behaviours, and urinary tract infections.
* For one consumer who has a suprapubic catheter and was unwell, care documentation evidenced a medical officer review was conducted and no abnormalities detected through testing for infections. The consumer remained unwell, however no vital observations were completed for a period of 12 days, and no further escalations occurred to identify the cause until transfer to hospital due to escalating pain levels where the consumer was diagnosed with urosepsis.
* For one consumer in the service’s memory support unit, care documentation identified unplanned weight loss with no recent review by a speech pathologist or dietitian. The consumer was observed sleeping most of the day throughout the Review audit and not participating in mealtimes. The service had not identified and escalated changes in the consumer’s condition until this information was brought to the attention of management by the assessment team.
* Registered staff did not demonstrate a shared understanding of changes relating to lethargy and appetite which may require escalation and were unaware of guidelines and flowcharts available at the service to guide staff in identifying deterioration.

The Provider’s response lacked information on immediate corrective actions taken to address the concerns raised regarding deterioration for the named consumer in the service’s memory support unit. The Provider advised of improvements such as staff education and training, escalation pathways and simulation drills, and regular audits and reviews to be completed by February 2025.

Having considered the Review audit report and the Provider’s response, I find deficiencies remain. Lack of registered staff knowledge and ineffective monitoring processes are resulting in inconsistent and untimely identification of deterioration and changes in consumers’ health and condition. In forming my view, I have also taken into consideration that the service had only recently returned to compliance in this Requirement under the performance assessment conducted 18 –19 June 2024. Previously identified deficiencies have reoccurred, and improvement actions have not been sustainable. Further improvements will require time to be embedded within the service’s processes and testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

**I find the remaining Requirements within this Standard compliant as:**

Most consumers and representatives said they are satisfied consumers’ care needs and preferences are communicated between staff and others who provide care. Care documentation evidenced input from medical officers and allied health professionals. Staff described how they are informed of recommendations from the medical officer and allied health professionals through handover processes, alerts, and information within the electronic care management system. Observation of handover demonstrated effective information sharing. Where 2 instances of inconsistencies in documented information was identified by the assessment team, this was addressed by management.

Most consumers and representatives were satisfied the service facilitates referrals to other health professionals and providers in a timely manner. Care documentation evidenced review and recommendations from health professionals and specialists based on consumers’ needs. Clinical management and registered staff demonstrated knowledge of the service’s referral processes.

Consumers and representatives expressed satisfaction with the service’s management of infection risks and outbreaks. Staff receive mandatory training in hand hygiene and use of personal protective equipment and demonstrated understanding of their role in infection control and antimicrobial stewardship. The service has appointed an infection prevention and control lead and implements infection control policies to guide staff. An outbreak management plan in place is currently under review for further updates. Management described processes to monitor consumer vaccination rates and increase in consumer uptake of the COVID-19 vaccine following vaccination clinics at the service.

# Standard 4

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

Findings

This Quality Standard is non-compliant as one of 7 Requirements have been found non-compliant. The non-compliance relates to the following:

* The service’s lifestyle program does not cater to the diverse needs and interests of consumers, encouraging consumers’ participation inside the service environment, social relationships, and to do things of interest to them.

I have made this decision based on the following analysis.

**Requirement 4(3)(c)**

The Review audit report identified the service did not demonstrate services and supports for daily living catered to the diverse needs and interests of consumers, including consumers in the service’s memory support unit. This includes:

* Consumers from various cultures voiced their desire to experience more cultural activities and celebrations related to their cultural background. Other consumers expressed disappointment in a Remembrance Day ceremony not being held at the service.
* Poor participation was observed for several activities with no more than 2 consumers attending. Consumers said, and staff confirmed, consumers decline attending activities stating these are boring and repetitive. Weekend activities consist solely of movies and colouring stations.
* Consumers and representatives said, and the assessment team observed, multiple scheduled activities being cancelled without notification to consumers.
* Some staff were unable to describe how they engage with consumers in accordance with their personal interests and preferences.
* The service has established lifestyle care plans, however charting under diversional care plans inaccurately records consumers’ participation in activities and attendance times.
* Representatives of consumers in the memory support unit expressed concerns regarding lack of stimulation for consumers. The daily activities schedule for the memory support unit did not align with activities being conducted. Activities were observed lacking staff engagement and interaction with consumers.

The service was previously found non-compliant in this Requirement following a Site Audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically in relation to lack of lifestyle activities catering to consumers’ needs and interests; incomplete lifestyle care plans; lack of lifestyle staff for the memory support unit and no availability of lifestyle staff on weekends; and lack of staff knowledge regarding consumers’ individual lifestyle needs. The service has since implemented some improvements such as recruiting lifestyle staff, establishing lifestyle care plans, and introducing a dedicated activity calendar for the memory support unit; however, improvement actions have either not been fully implemented or not been evaluated for effectiveness.

The Provider’s response acknowledged continued efforts are required to strengthen the service’s lifestyle program to ensure it caters to consumers’ individual needs and interests. The Provider advised of immediate corrective actions implemented such as an apology provided to consumers for the service’s oversight in not celebrating Remembrance Day; establishing a stand-alone events calendar for various cultural days and special events; review of the lifestyle schedule by the service’s consumer advocates; and consultation with the consumer cohort to redesign the lifestyle schedule. The Provider further advised the organisation’s Board has approved extensive refurbishment of the service’s memory support unit. New sensory stimulation activities are to be introduced for consumers. Lifestyle staff will undergo training through external providers. Oversight and management of the service’s lifestyle program and the need for a more suitably experienced and qualified person to drive the program is currently under review. Improvements are planned for completion between December 2024 – March 2025.

Having considered the Review audit report and the Provider’s response, I find deficiencies remain ongoing. Consumers are not currently supported to participate in meaningful and engaging activities within the service and to do things of interest to them. Planned improvements will require time for implementation and testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

**I find all other Requirements within this Standard compliant as:**

Consumers and representatives said the service provides safe and effective services and supports to assist consumers to remain independent and maintain their wellbeing and quality of life. Care planning documentation and handover notes include information to guide staff regarding the support consumers require to remain independent. Staff demonstrated knowledge of the individual needs of consumers and the supports provided to them.

Consumers and representatives said services and supports provided assist consumers’ emotional and spiritual wellbeing. Staff described various ways they support consumers’ emotional and spiritual wellbeing. If consumers are identified as feeling low, the service organises referrals to mental health services, one-on-one support from lifestyle staff, and/or visits from a pastor as per the consumer’s needs. Care plans include information to guide staff practice regarding each consumer’s emotional and spiritual wellbeing needs.

Consumers and representatives said information regarding the consumer is communicated effectively. Staff said information regarding consumers is shared through handover and care plans. Changes to dietary requirements are effectively communicated to kitchen staff. Care documentation identified consumer information is communicated with others to ensure service and supports are delivered without disruption.

The service demonstrated effective processes to provide referrals to other providers of care and services. Consumers described having access to hairdressing, physiotherapy, and other services based on their needs. Staff explained the process they follow should consumers require referrals to the visiting pastor or mental health support services. Review of care planning documentation evidenced recording of referrals to other health professionals and providers.

Consumers provided positive feedback regarding the variety, quality, and quantity of meals provided. Kitchen and care staff demonstrated knowledge of individual consumers’ dietary requirements and the processes to ensure they receive the correct meals. The service implements a rotating monthly menu with feedback sought via consumer meetings, food focus meetings, and other mechanisms.

Consumers and representatives expressed satisfaction with the equipment available for consumers’ daily living needs. Equipment was observed to be kept clean and well-maintained. Staff said they receive training to safely assist consumers to use mobility equipment and were observed cleaning equipment between use. Maintenance staff described preventative maintenance schedules and processes to report and action maintenance requests.

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

Findings

**Requirement 5(3)(b)**

Consumers and representatives provided positive feedback regarding the cleanliness and maintenance of the service environment and the ability for consumers to move freely inside and outside the service. The service was observed to be kept clean and well-maintained, with consumers moving independently or with staff assistance throughout the service. A designated smoking area is available to consumers equipped with appropriate seating, signage, and fire safety equipment.

The service’s memory support unit includes a large secure outdoor area which was observed accessible to consumers. Representatives of consumers in the memory support unit commented positively regarding consumers’ freedom of access to the secure outdoor area. Additionally, the Provider’s response as identified under Requirement 4(3)(c) advises of Board approval for extensive refurbishment to the indoor and outdoor memory support unit environment in coming months.

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically due to lack of access to the secure outdoor area for consumers within the memory support unit; and lack of consumer access to residential floors within the service’s main building due to consumers not having been assessed for their ability to use a coded keypad to access the elevator. The service demonstrated the following actions have been implemented to remediate these deficiencies:

* Doors allowing access to the secure outdoor area in the memory support unit have been opened to support free movement.
* The height of the coded keypad has been adjusted to enable all consumers to access this, with the 4-digit code clearly displayed beside the keypad. Assessments have been conducted for all consumers requiring access across all floors of the service’s main building via the elevator to ensure their capacity to use the keypad. Appropriate environmental restraint authorisation and consent forms have been completed for any consumers assessed as not having capacity to use the keypad independently.

Based on the information recorded above, and the positive feedback received from consumers/representatives, I find this Requirement compliant.

**I find all other Requirements within this Standard compliant as:**

Consumers and representatives said, and observations identified, the service is welcoming and easy to navigate with wide hallways, adequate signage, and access to large communal areas for socialising. Outdoor areas provide adequate seating and shaded spaces. Consumers are encouraged to personalise their rooms reflecting their individual preferences.

The service demonstrated furniture, fittings, and equipment are kept safe, clean, well-maintained, and suitable for consumer use. Consumers said maintenance requests are attended to promptly. Staff demonstrated knowledge of reporting processes for repair to equipment. A preventative maintenance schedule is implemented which identified regular equipment safety checks. Review of documentation such as maintenance logbooks identified prompt resolution of reported maintenance issues.

# Standard 6

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

Findings

Consumers and representatives said they are supported and encouraged to provide feedback or make a complaint and felt comfortable in voicing their concerns. Management described, and review of documentation identified, consumers and representatives are supported to provide feedback or raise a complaint in various ways including through monthly meetings, speaking with staff or management directly, or completing feedback forms. Staff described how they support consumers who wished to provide feedback or make a complaint.

Consumers and representatives said they are aware of advocacy and language services available to consumers. Staff demonstrated knowledge of access to advocacy agencies and interpreting services to assist consumers who may require these services. Information on advocacy and interpreter services and external complaints agencies is included in the service’s consumer handbook and was observed available via brochures and posters throughout the service.

Consumers and representatives said management are responsive to feedback and complaints and provided examples of how their concerns have been resolved promptly. Management and staff demonstrated knowledge of the service’s processes to address feedback and complaints. Policies, procedures, and training on feedback and complaints handling and open disclosure are available to guide staff practice. Review of the service’s feedback and complaints register identified complaints are addressed in a timely manner and open disclosure is documented.

Consumers and representatives felt confident the service uses feedback and complaints to improve the quality of care and services. Management advised the service conducts monthly trending and analyses of feedback and complaints and uses this information to inform continuous improvement activities. Management and staff described how feedback and complaints are discussed during staff and consumer/representative meetings, and at handover to enhance problem solving and identify improvement measures. The service’s plan for continuous improvement evidenced various improvements made in response to feedback and complaints.

Based on the information recorded above, I find all Requirements within this Standard 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. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

This Quality Standard is non-compliant as one of 5 Requirements has been found non-compliant. The non-compliance relates to the following:

* Not demonstrating registered staff and lifestyle staff are appropriately trained, equipped, and supported to deliver outcomes required under the Quality Standards.

I have made this decision based on the following analysis.

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

Most consumers and representatives said staffing enables the provision of care and services in a timely manner. Review of rosters and allocation sheets demonstrated vacant shifts are generally filled and staff said they have enough time to complete their duties. Management advised the service conducts monthly call bell auditing and any extended response times are investigated to identify the cause and prevent recurrence. Review of recent monthly call bell reports identified an average response time of 4 minutes. The organisation has created 2 new clinical roles to support the service’s registered staff, as well as a Group manager role to provide oversight of clinical and operational performance of the service.

The service was previously found non-compliant in this Requirement following an assessment contact dated 14 - 15 June 2023, a Site audit dated 26 - 29 September 2023, and an assessment contact dated 18-19 June 2024. The non-compliance was specifically due to delayed response to call bells and lack of call bell data analysis/review; lack of lifestyle staff; and clinical management stating they have no time to complete their duties and to performance manage underperforming staff. The service demonstrated the following actions have been implemented to remediate these deficiencies:

* Implementation of a new workforce management system to allow the service to ensure coverage of shifts within the roster and enable staff to ‘bid’ for vacant shifts.
* Creation of 3 care staff ‘float’ roles to provide additional support to consumers between residential wings where required, including manual handling.
* Recruitment of 3 lifestyle staff in addition to the Lifestyle coordinator, with each being dedicated to a section of the service, including the memory support unit.
* Monthly reporting on call bell response times as well as weekly monitoring of response times by management to enable contemporaneous investigation of any identified extended response times.
* Implementation of a register to track and monitor the performance of staff, manage underperforming staff, and ensure staff performance appraisals are up to date.

The Provider’s response includes additional information on recent recruitment to fill newly created Quality assurance nurse and Group clinical lead positions at the organisational level to ensure clinical auditing, mentoring, oversight and support to the service’s clinical management team. A third clinical nurse manager has been recruited to the service and the service’s Head of care position vacant at the time of the Review audit has been filled since 2 December 2024.

I note additional information brought forward under other Requirements in the Review audit report in relation to non-compliance with care minutes and clinical management being required to complete work of registered staff preventing effective clinical oversight. I have considered these matters within the context of regulatory compliance, workforce governance, and clinical governance under Requirements 8(3)(c) and 8(3)(e). In forming my view of compliance in this Requirement, I have placed greater weight on feedback from consumers/representatives and staff regarding adequacy of staff numbers at the service and the improvements made in this regard.

Based on the information recorded above, I find this Requirement compliant.

**Requirement 7(3)(b)**

Consumers and representatives provided positive feedback regarding workforce interactions and confirmed staff are kind, caring, and treat consumers well. Management described how the service utilises regular observations and consumer/representative feedback to monitor staff behaviour and ensure interactions between staff and consumers meet the organisation’s expectations. Review of care documentation identified staff use respectful language when describing consumers’ care needs and information regarding their diversity and preferences is documented to guide staff practice. Staff were observed interacting with consumers respectfully and in a kind and caring manner.

Based on the information recorded above, I find this Requirement compliant.

**Requirement 7(3)(c)**

Consumers and representatives said they felt the workforce is competent and staff have the knowledge to deliver care and services according to their role. Staff described the training, professional development, and supervision they receive during orientation and on an ongoing basis. Management advised and staff confirmed additional training is provided where requested or identified during performance development processes. Management discussed how new staff provide documentary evidence of qualifications and suitability to undertake their role prior to commencement. Processes are in place to track and monitor staff registrations and police checks. Management advised staff competency is determined through line manager feedback, competency assessments, performance appraisals, consumer/representative feedback, and surveys.

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically due to consumer/representative feedback regarding lack of staff competency resulting in instances of consumers experiencing indignity and/or rough handling; staff stating they require more training to manage challenging behaviours; care staff advising they are rushed due to staff shortages resulting in unsafe work practices; and lack of staff knowledge regarding serious incident reporting, restrictive practices, and post-fall management. The service demonstrated the following actions have been implemented to remediate these deficiencies:

* Ensuring staff undertake a range of online and face to face training workshops, including through external providers in dementia care, serious incident reporting, manual handling, and minimising the use of restrictive practices.
* Provision of training and knowledge testing for registered staff and clinical management on psychotropic registers, behaviour support plans, and restraint.
* Provision of a 4-day clinical training program for registered staff on clinical skills and leadership.
* Creation of 3 care staff ‘float’ roles to provide additional support to consumers between residential wings where required, including manual handling.

In forming my view of compliance with this Requirement, I have placed weight on consumer/representative feedback regarding staff competency and evidence identifying deficiencies have for the most part been addressed, and staff have demonstrated knowledge of serious incident reporting and restrictive practices. I note ongoing concerns remain regarding the training of registered staff and lifestyle staff, as well as gaps in serious incident reporting and completion of behaviour support plans. I have considered this within the context of the service’s lack of clinical oversight and monitoring as part of workforce governance and clinical governance under Requirements 8(3)(c) and 8(3)(e), as well as the service not ensuring these staff are appropriately trained, equipped and supported to perform their roles under Requirement 7(3)(d).

Based on the information recorded above, I find this Requirement compliant.

**Requirement 7(3)(d)**

The Review audit report brought forward information identifying whilst the service has established a mandatory staff training program and demonstrated 100% compliance, the service has not demonstrated lifestyle staff and registered staff are appropriately trained, supported, and equipped to perform their roles. This included:

* Lifestyle activities are either not being consistently conducted and/or do not support the needs and interests of consumers. Incorrect recording of consumer attendance under diversional care plans. Lack of communication with consumers and representatives regarding new or cancelled activities. Refer to Requirement 4(3)(c) for further information.
* Concerns regarding training of registered staff to perform their duties effectively. This includes but is not limited to, lack of individualised behaviour support plans; not ensuring appropriate wound management; not effectively managing pain for consumers at end of life; PEG management and enteral feeding; not identifying and responding to deterioration; and not ensuring consistent and appropriate documentation and record-keeping as identified under Standards 2 and 3.
* Clinical management advised they are completing tasks usually assigned to registered staff due to their lack of capability, preventing effective clinical oversight and monitoring from occurring.

The Provider’s response acknowledges further training and support required by lifestyle and registered staff. The Provider advised recruitment of a third clinical manager to strengthen the service’s clinical management team and recent recruitment to fill the vacant Head of care position will alleviate the workload of clinical management and ensure provision of appropriate oversight and support to registered staff. The Provider submitted supporting documentation to evidence planned improvement actions including a 3-day intensive training program for lifestyle staff, a 4-day professional development program for registered staff, and a range of education and training sessions under the service’s education calendar. Improvement actions are to be completed between January - April 2025.

Having considered the Review audit report and the Provider’s response, I find the service has not demonstrated lifestyle staff and registered staff are currently appropriately trained, supported, and equipped to deliver outcomes under the Quality Standards. Improvement actions in the form of staff education and training will require time to be embedded within the service’s processes and testing to demonstrate effectiveness.

I, therefore, find this Requirement non-compliant.

**Requirement 7(3)(e)**

The service demonstrated systems and processes in place to regularly assess, monitor, and review staff performance. Staff confirmed they have participated in performance appraisals and can request specific training relevant to their role. Clinical and service management advised staff performance is monitored through observations, analysis of clinical data, and consumer/representative feedback. Review of documentation identified staff performance appraisals are up to date and include staff and manager input and areas for further training and development.

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically due to performance appraisals not having been conducted in 12 months; lack of a performance management system; and clinical management stating they did not have time to manage underperforming staff. The service demonstrated the following actions have been taken:

* Implementing a workforce performance assessment policy to establish the requirement for probationary and ongoing performance appraisals, as well as processes for managing underperformance.
* Establishing a performance management system and register to track and monitor performance appraisals for all staff, including clinical and service management.
* Completing outstanding performance appraisals.
* Undertaking formal performance management of staff, where required.

Based on the information recorded above, I find this Requirement compliant.

# Standard 8

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

**Findings**

This Quality Standard is non-compliant as 3 of 5 Requirements have been found non-compliant. The non-compliance relates to the following:

* Not demonstrating effective organisation-wide governance systems in relation to continuous improvement, workforce governance, and regulatory compliance.
* Not demonstrating effective systems and processes to ensure management of high-impact and high-prevalence risks and consistent serious incident reporting.
* Ineffective clinical governance systems and practices.

I have made this decision on the following analysis.

**Requirement 8(3)(a)**

Consumers and representatives felt the service is well run and they have multiple opportunities to provide feedback on care and services which is considered by management. Management described various avenues for consumers to be involved in the development and evaluation of care and services including but not limited to, monthly consumer meetings and quarterly representative meetings, periodic surveys, and feedback and complaints mechanisms. Two of the service’s consumers participate in quarterly quality care advisory body meetings. Review of the service’s plan for continuous improvement identified improvements to care and services in response to consumer and representative feedback.

Based on the information recorded above, I find this Requirement compliant.

**Requirement 8(3)(b)**

Consumers and representatives said consumers feel safe and respected at the service and are confident in the service addressing feedback and complaints appropriately. Management described how the governing body monitors the service’s compliance with the Quality Standards. Regular meetings and reporting processes are established to ensure communication of information across various areas to the Board. Fortnightly manager meetings are conducted to provide operational and clinical updates to the Chief Executive Officer. Monthly quality and compliance improvement committee meetings have been commenced reporting to the Board.

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically due to ineffective information management and incident reporting systems; information on insufficient staffing not being provided to the Board; lack of clinical monitoring; and consumer/representative feedback expressing concerns regarding lack of safety, dignity, and fear of reprisal. The service demonstrated the following actions have been implemented:

* The organisation established a new mechanism within their incident management system for recording incidents falling under the Serious Incident Response Scheme. Whilst some gaps were identified in consistent reporting of incidents, this information has been considered within the context of Requirement 8(3)(c) and 8(3)(d) below.
* Regular reporting to the Board which includes information on occupancy, care minutes, and workforce planning to enable oversight of staffing sufficiency.
* Commencement of quality care and compliance committee meetings to review clinical indicators, operational performance, and risks, and to report this information to the Board.
* Provision of training to staff on consumer dignity and choice, manual handling, and serious incident reporting.
* Various improvement actions to encourage feedback and complaints including letters to consumer/representatives, initiating a quarterly representatives meeting, and including feedback and complaints as a standard agenda item in monthly consumer meetings.

Based on information recorded above, I find this Requirement compliant.

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

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance was specifically in relation to:

* Information management: inability of new and agency staff to access the electronic care management system; lack of staff handovers; and ineffective information management systems.
* Continuous improvement: lack of monitoring and review processes for improvement actions within the service’s plan for continuous improvement.
* Workforce governance: insufficient staff; ineffective workforce planning; and staff stating they are rushed and do not have enough time to complete their duties.
* Regulatory compliance: lack of staff knowledge and monitoring processes related to restrictive practices and serious incident reporting.
* Feedback and complaints: inconsistent recording of feedback and complaints and fear of reprisal expressed by consumers and representatives.

The Review audit report identified:

* Information management
* The service has implemented various improvements including regular staff handovers and staff meetings; written handover sheets; staff training on the electronic information management system; access to policies and procedures via an intranet page; and weekly analysis and reporting of information. However, the Review audit report identified inconsistencies in documenting of consumers’ information as identified under Standards 2 and 3, and therefore recommended ongoing non-compliance.
* Continuous improvement:
* The service’s continuous improvement plan has been updated to include a section on evaluation of improvement actions. Continuous improvement is monitored via fortnightly heads of department meetings and monthly quality and improvement committee meetings and is reported to the Board. The continuous improvement plan demonstrates improvement areas are identified via various sources. The Review audit report recommended the service has returned to compliance in relation to continuous improvement.
* Financial governance:
* Management described financial governance processes in place and how they seek changes to budget and expenditure to support the changing needs of consumers.
* Workforce governance:
* A range of improvements have been implemented including a new workforce management system; monthly call bell analysis and reporting; recruitment of new lifestyle staff and clinical staff; creation of ‘float’ care staff roles; new performance management policies, processes and systems; and provision of staff training on various topics.
* However, the Review audit report recommended ongoing non-compliance. This was specifically due to the organisation’s workforce governance systems and processes not identifying lifestyle staff and registered staff are not being appropriately trained, equipped, and supported to perform their role; and clinical management having to perform the duties of registered staff resulting in their inability to ensure clinical monitoring and oversight.
* Regulatory compliance:
* The service has made improvements such as provision of training to staff on serious incident reporting and restrictive practices. However, the service is not complying with regulatory obligations in relation to establishing a consumer advisory body; consistently meeting minimum care minute requirements for care and registered staff; ensuring membership of the organisation’s governing body includes a majority of independent non-executive members; and ensuring consistent reporting of serious incidents under the Serious Incident Response Scheme.
* Feedback and complaints:
* The service has made various improvements such as implementing a feedback and complaints handling policy; commencing quarterly meetings with representatives; encouraging submission of feedback and complaints; and regularly discussing these via monthly consumer meetings. Consumers and representatives provided positive feedback regarding feedback and complaints mechanisms and expressed confidence in the service addressing complaints appropriately. The Review audit report recommended the service has returned to compliance in this regard.

I am satisfied the service has demonstrated effective systems in relation to feedback and complaints and financial governance.

Regarding information management, I have formed a different view to the assessment team as I have placed weight on the significant improvements to information management systems and processes implemented at the service. I do not consider incomplete/inconsistent clinical documentation under Standard 2 and 3 demonstrates ineffective information management systems. I attribute this to ineffective clinical oversight and monitoring.

Regarding continuous improvement, I have formed a different view to the assessment team as I have considered the service’s history of non-compliance. Whilst the Provider has demonstrated a return to compliance in 6 Requirements, ongoing non-compliance remains for 6 Requirements due to the service not completing improvement actions and/or not evaluating these for effectiveness. The Review audit report additionally identified a further 6 Requirements as non-compliant. This includes a recurrence of previously identified deficiencies under Requirements which had only recently returned to compliance in the performance assessment conducted 18 – 19 June 2024. The organisation’s continuous improvements systems have failed to self-identify gaps and remediate these in a timely manner.

Regarding workforce governance, in addition to issues identified in the Review audit report I have also considered the service’s history of high turnover of senior management and clinical staff, including extended periods of vacancy in these positions. The Provider’s response acknowledges this is the first time since February 2024 that there is a full clinical management team in place at the service. Stability in management and senor clinical roles is imperative to the service’s progress against planned improvements to ensure a return to compliance. I am not satisfied the Provider has demonstrated effective workforce governance at present to support this.

The Provider’s response includes information on various corrective actions and planned improvements. Specifically in relation to regulatory compliance, the Provider has advised expressions of interest have now been sought from consumers and representatives to form a consumer advisory body. The Provider has refuted calculations regarding care minutes cited in the Review audit report and maintains it is currently meeting care minute targets; however, no supporting documentation has been provided to evidence this. Regarding the organisation’s Board structure, the Provider has advised it has applied for a review of the Commission’s decision on governing body requirements. Delays in reporting for some incidents was acknowledged and improvements made as outlined under Requirement 8(3)(d). I am not satisfied the Provider is currently meeting its regulatory compliance responsibilities.

Having considered the Review audit report and the Provider’s response, I find deficiencies in continuous improvement, workforce governance, and regulatory compliance remain.

I, therefore, find this Requirement non-compliant.

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

The Review audit report identified the following deficiencies in relation to the management of high-impact and high-prevalence risks to consumers at the service and serious incident reporting:

* Policies and procedures on managing high-impact and high- prevalence risks are available, and monitoring processes established. However, these are not being effectively implemented and risks to consumers are not being effectively managed as identified under Requirement 3(3)(b).
* Whilst staff have been provided training on serious incident reporting and demonstrated sound knowledge of this, a number of serious incidents were identified as not having been reported under the Serious Incident Response Scheme or reported outside of mandatory reporting timeframes. This included 2 incidents where maggots were identified in consumers’ wounds.
* Review of behaviour charts evidenced several instances of physical and verbal altercations between consumers that had not been identified as an incident.

The Provider’s response includes information on a new risk and incident management system implemented at the service since early December 2024 and strengthened incident identification, escalation, reporting, and oversight processes. Newly created Quality assurance nurse and Group clinical lead positions have been filled at the organisational level to ensure clinical auditing, mentoring, oversight and support to the service’s clinical management team. There is now increased support to registered staff via recruitment of a third clinical manager and filling of the vacant Head of care position.

Having considered the Review audit report and the Provider’s response, I find deficiencies remain. In forming my view, I have also taken into consideration the service had only recently returned to compliance in this Requirement under the performance assessment conducted 18 – 19 June 2024. Previously identified deficiencies have reoccurred, and improvement actions have not been sustainable. Further improvements will require time to be embedded within the service’s processes and testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

**Requirement 8(3)(e)**

The service was previously found non-compliant in this Requirement following a Site audit dated 26 - 29 September 2023 and an assessment contact dated 18 -19 June 2024. The non-compliance related to lack of systems and processes to monitor clinical governance and ensure incident reporting; inconsistent pain assessments and post-fall neurological observations; and lack of staff knowledge and management of restrictive practices.

The Review audit report identified the service has implemented improvements to strengthen clinical governance such as extensive staff training and education, monthly clinical trending and analyses, and conducting fortnightly clinical meetings to discuss high risk consumers. The organisation has established and filled new roles of Group manager and Quality assurance nurse to provide oversight and support to the service’s clinical management team. However, the Review audit report identified:

* Clinical monitoring and oversight processes are inactive, not consistently occurring, or are ineffective.
* Clinical management are completing tasks ordinarily allocated to registered staff preventing them from ensuring effective clinical monitoring and oversight.
* Behaviour support plans for consumers are either generic or incomplete.
* Registered staff are not trained, equipped, and supported to perform their roles.
* Previous deficits in relation to inconsistent pain assessments and post-fall neurological observations, inconsistent incident reporting, and lack of management of restrictive practices remain ongoing.
* Gaps in clinical assessment, planning, and care delivery for consumers have not been self-identified by the service and remediated.

The Provider’s response advises of increased support and training for clinical management and registered staff, mentoring sessions with the Group manager and Group clinical lead, and commencement of an internal auditing program. Various other planned improvements are outlined under other Requirements within this report.

Having considered the Review audit report and Provider’s response, I find deficiencies remain. I acknowledge the Provider’s efforts to strengthen clinical governance at the service. However, I consider these clinical governance systems and processes to be currently at a developing stage. Stability within the service’s clinical management team is critical to effective clinical governance and I am not satisfied the Provider has demonstrated satisfactory workforce governance at present to ensure this. Improvement actions will require time to be embedded within the service’s processes and testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

1. The preparation of the performance report is in accordance with section 76A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)