Performance

Report

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| Name: | Merrimac Park Private Care |
| Commission ID: | 5746 |
| Address: | 50-52 Macadie Way, MERRIMAC, Queensland, 4226 |
| Activity type: | Site audit |
| Activity date: | 26 September 2023 to 29 September 2023 |
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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 B 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 Site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* the provider’s response to the assessment team’s report received 20 October 2023.

# 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 6** Feedback and complaints | **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.

* Consumers must be treated with dignity and respect.
* The organisation must undertake initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning must have a focus on optimising consumer health and well-being in accordance with consumers’ needs, goals and preferences.
* The organisation must deliver safe and effective personal and clinical care in accordance with consumers’ needs, goals and preferences to optimise health and well-being.
* The service must ensure consumers are enabled to maintain relationships of importance and do things of interest to them.
* The service environment needs to enable consumers to move freely throughout the service both indoors and outside and provide a welcoming environment.
* The workforce needs to be planned to enable, and the mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* The workforce needs to be appropriately trained to perform their roles and undergo regular assessment of their work performance.
* The organisation must have effective organisation wide governance systems.
* The organisation must have effective risk management systems and practices.

# 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 |
| 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

This Quality Standard has been found Non-Compliant as one of six Requirements have been found Non-Compliant. The non-compliance is related to the following:

* The service is not demonstrating the dignity of each consumer is maintained or their diversity valued.

I have made this decision based on the following analysis.

Requirement 1(3)(a)

Information in the site audit report indicated consumers who require staff assistance with personal and hygiene care are not treated with dignity due to consumers being left to wait for staff assistance for extended periods of time resulting in incontinence; soiled continence aids not being changed in a timely manner; and the absence of understanding of consumers’ individuality and diversity needs. For example,

* a named consumer in the Memory Support Unit (MSU) was observed to have remained in a soiled incontinence aid for a period of one and a half hours before being attended to. The representative of this consumer said they find them soiled frequently when visiting. The representative said they had not witnessed staff ever attempting to communicate with the consumer in their native tongue (Italian) and felt the consumer’s dignity was not respected.
* Other consumers and representatives complained of episodes of incontinence occurring due to staff not providing assistance with toileting in a timely manner.
* Staff advised they were unable to attend in a timely manner due to the large proportion of consumers who required two person assists for care.
* When interviewed, some staff were unaware of consumers’ backgrounds and interests. Representatives expressed the view that some staff did not value consumers. For example, staff caring for a consumer were unaware they had played representative football and maintained a keen interest in the game. Another representative said staff made no attempt to communicate with his father using Italian, which is his native language.

In responding to the site audit report, the approved provider noted as general objection that they were already working with the Commission to address previously identified non-compliance and that the site audit could have been delayed. The provider noted the site audit created significant anxiety for staff who were already under pressure to implement previously agreed improvements.

With regards to Requirement 1(3)(a) the provider response advised the following;

* Additional staffing of the MSU has been implemented to reduce waiting times for assistance to be provided to consumers and to maintain services when staff are engaged in two person assists.
* Call bell audits will track response times to consumer requests for assistance and staff have been reminded of the importance of responding promptly.
* care interaction observations are to be commenced and continued on a weekly basis.
* Lifestyle staff are already engaged in the MSU, and interviews are underway to obtain another lifestyle officer with dementia specialisation.
* Communication aids in different languages are to be purchased.

I acknowledge the concerns raised by the approved provider and the actions taken in response to the site audit report. However, having considered the site audit report and the provider's response, I am not satisfied the service has demonstrated each consumer is treated with dignity and respect or receives safe and effective care in relation to continence care.

I have therefore decided Requirement 1(3)(a) is Non-Compliant.

I find the other 5 Requirements of Standard 1 Compliant as:

Most consumers/representatives felt that the service delivered culturally safe care and involved them in planning of services to meet their cultural preferences. The service celebrated days of cultural significance to consumers and care documentation identified the cultural care needs of consumers.

Consumers described how they are supported to maintain relationships and connections with people important to them. Consumers gave examples of how they exercise choice and independence. Staff described how consumers are supported to make informed choices about their care and services such as through menu selection, participation in activities, choosing their care preferences and who they wish to be involved in decisions about their care.

Consumers were supported by staff to take risks and make choices to support their self-determination. Consumer risk assessments were completed to support consumers to understand and undertake risks that maintain their quality of life. Risk related activities included consumers choosing to leave the service to attend personal activities and choosing to smoke.

Consumers and representatives said they were provided enough information to assist consumers in making informed choices on such matters as lifestyle activities and meal selections. Consumers attend consumer meetings and food focus groups where information is provided. A range of information such as a lifestyle activity calendars, information on noticeboards, feedback forms and advocacy material were observed to be available to consumers around the service.

Consumers and representatives confirmed consumers’ personal privacy is respected and information is kept confidential. Staff were observed knocking on doors before entering consumers’ rooms and seeking consent prior to attending to consumers. Care documentation recorded the privacy requirements of individual consumers.

# 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)(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. | Not Compliant |

Findings

This Quality Standard has been found Non-Compliant as three of five Requirements have been found Non-Compliant. The non-compliance is related to the following:

* Assessment and planning did not consistently consider risks to consumers and assessment and planning for most consumers was not current.
* Advanced care planning and end of life planning was not maintained to reflect consumers current needs.
* Care and services were not reviewed regularly.

I have made this decision based on the following analysis.

Requirement 2(3)(a)

Information in the Site audit report indicated care plans for the majority of consumers had not been reviewed within six months.

Care documentation for most consumers subject to restrictive practice did not include risk assessments or Behaviour Support Plans (BSP). Consent forms for restrictive practice were often incomplete.

Clinical management did not demonstrate a process for the effectively identifying and managing assessment and documentation requirements for restrictive practices.

Review of the psychotropic register indicated it was incomplete as it did not identify consumers who are subject to a chemical restraint or the circumstances for administering chemical restraint.

In their response to the Site audit report the provider advised;

* All care plan evaluations have been brought up to date.
* A detailed risk register has been developed to capture risks to individual consumers across the facility. A copy of this was provided with the response.
* An audit of BSPs has been conducted and 12 plans due for updates are being worked through systematically.
* The psychotropic register will be updated by the pharmacy following General Practitioner reviews (which have occurred) updating the indications for prescriptions.

Having considered the site audit report and the provider's response, I acknowledge the remedial actions undertaken by the service since the site audit. However, on the evidence before me I cannot be satisfied the service has demonstrated effective systems to ensure care plans are maintained and reviewed or that assessment, planning and documentation for consumers subject to restrictive practices is adequate.

Therefore, I have decided that Requirement 2(3)(a) is Non-Compliant.

Requirement 2(3)(b)

Information in the site audit report indicated care documentation for consumers often did not identify or address the current needs of consumers. Examples included;

* The care plan for a consumer known to suffer from Urinary Tract Infections (UTI) and dehydration not including hospital discharge information recommending prompting the consumer to consume water.
* Behaviour management strategies devised by an external dementia specialist agency were not included in a consumer’s behaviour chart, and;
* A consumer with an indwelling catheter whose care documentation did not include a catheter management plan.

Management advised consumer documentation had not been maintained due to staff shortages and lack of knowledge of staff.

In responding to the site audit report the approved provider advised that the introduction of a risk register has provided greater oversight in relation to the clinical risks throughout the facility.

Having considered the information in the site audit report and the provider’s response I am not satisfied the service is ensuring care documentation reflects the current needs of consumers based on the evidence of essential information missing from consumer care documentation.

Therefore, I have decided that Requirement 2(3)(b) is Non-Compliant.

Requirement 2(3)(e)

Information in the site audit report indicated that a review of care planning and incident documentation revealed 64 care plans were overdue and 171 incidents had not been evaluated to identify any changes needed to consumers’ care. Examples included;

* A consumer demonstrated frequent agitation, verbal and physical aggression, often multiple times a day on most days. However, there was no evidence of review of the incidents to determine contributing factors, effectiveness of current behaviour management strategies or identify changes needed.
* A consumer had 29 falls over a three-month period, however, most of those incidents had not been evaluated or reviewed to determine how their current fall mitigations strategies could be improved.
* Management acknowledged reviews of incidents had not been completed to identify where changes in care delivery may be needed.

In response to the site audit report, the approved provider advised all care plan evaluations have been brought up to date as of 17 October 2023. A full cross check of Serious Incident Response Scheme (SIRS) incidents is being undertaken.

Having considered the information in the site audit report and the provider’s response, and considering the evidence before me, I am not satisfied the service is reviewing care and services for effectiveness and updating consumer care documentation in response to changes in consumer’s circumstances or following incidents.

I therefore find Requirement 2(3)(e) is Non-Compliant.

I find Requirement 2(3)(c) Compliant as consumers and representatives said they were satisfied with how the service involves them in assessment and planning processes and includes other organisations and providers of care as required. Care documentation evidenced the involvement of consumers and their representatives as well as external providers of care. Staff were able to describe how they ensure consumers and representatives are involved in assessment and planning processes.

I find Requirement 2(3)(d) Compliant as the service was able to demonstrate the outcomes of assessment and planning are communicated effectively to consumers and representatives. Consumers said they were provided copies of their care plans if they wanted them, and that staff communicated information in the assessment and planning documentation to them in a way they understood.

# 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. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not 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. | Not 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 has been found Non-Compliant as four of seven Requirements have been found Non-Compliant. The non-compliance is related to the following:

* The service could not demonstrate all consumers receive safe and effective personal and clinical care tailored to their needs.
* The service could not high impact or high prevalence risks for consumers were being effectively managed.
* Recognition of deterioration and response to changes in consumers’ conditions
* Transmission of information about the condition, needs and preferences of consumers within the organisation and with others responsible for care.

I have made this decision based on the following analysis.

Requirement 3(3)(a)

Following an Assessment Contact conducted 14 June 2023 and 15 June 2023 the service was found Non-Compliant in Requirement 3(3)(a). Deficiencies related to;

* Care documentation did not support consumers to receive care that was best practice to optimise consumers’ health and well-being and staff did not have a shared understanding of consumers’ needs.

Information in the Site report indicated consumers in the MSU were not receiving effective care in relation to challenging behaviours and falls risks. Additionally, the service could not demonstrate effective care systems to ensure best practice tailored care in relation to clinical care.

The site report indicates the deficiencies previously identified regarding care documentation have not been rectified. For example;

* For three consumers receiving chemical restraint, care documentation does not record or indicate any alternate strategies were trialled prior to administration of the chemical restraint. On most occasions there was no evaluation of the effectiveness of the chemical restraint recorded.
* For four consumers who have a history of falling frequently, care documentation did not always record that appropriate post falls management had occurred, including the completion of neurological observations. Staff said they were aware that this was not being consistently completed.
* For two consumers identified as having pain as a contributing factor to challenging behaviours, the care documentation did not demonstrate non-verbal pain assessments were being completed. Management said they did not have systems for monitoring whether staff had completed the assessments.

The consequence of incomplete care documentation is increased risk for the clinical care of consumers. For example, in relation to the situations described above.

* For two of the consumers receiving chemical restraint, it is listed as the first strategy to be used in their Behaviour Support Plans (BSP). Handover documentation also records the use of the restraint has been the first option for management of challenging behaviours. This is counter to the requirements of the Quality of Care Principles 2014. Staff did not demonstrate an understanding of trialling alternative strategies prior to administering chemical restraint.
* While staff were able to describe assessments and observations required after a consumer has a fall, the site audit contained an example of a consumer found on the floor who was not assessed until the following day when it was identified they were exhibiting signs of pain and bruising.
* The care documentation for the two consumers identified as having pain as a contributing factor to their challenging behaviours records instances in September 2023 where chemical restraint was administered without adequate investigation or assessment of pain as the potential cause for the challenging behaviour.

Care documentation for a consumer with Parkinson’s disease requiring time sensitive medication indicated it was often administered early or late.

The care documentation for a consumer with complex wounds requiring charting was incomplete which made it impossible to determine whether or not the wound care had occurred as directed.

In response to the Site audit report the provider advised;

* BSPs are being reworked to support the minimisation of restrictive practice.
* All wound care plans have been updated and pain is being assessed at each dressing interaction.
* Staff have been reminded about the importance of time sensitive medication administration.
* A pain assessment audit has been conducted with significant improvement in pain assessments, records and follow up notes.

After considering the information in the site report and the providers response, I acknowledge the actions taken by the provider since the site audit. Some of these actions are yet to be fully implemented and will take time to be evaluated. I am not currently satisfied the service is ensuring care documentation supports effective clinical care to optimise consumers’ health and well-being.

I therefore find Requirement 3(3)(a) Non-Compliant.

Requirement 3(3)(b)

Information in the site report indicated representatives for consumers residing in the MSU expressed concerns with the management of risks relating to falls, behaviour management and skin integrity.

Incident management records showed they were 317 falls in the service in the three months prior to the site audit. Five consumers in the MSU had more than 20 falls each during that time. A review of the incidents indicated the majority did not include any evaluation or actions taken in response.

There were 208 incidents of new skin tears or wounds in the three months. Four consumers had multiple skin tears or wounds recorded in that time. Some of these consumers were also identified by the Assessment Team as being frequent fallers, however, this connection had not been made by the service. Strategies had not been implemented to improve outcomes and care for consumers with skin tears or wounds.

The site report indicated a lack of management systems to ensure high impact, high prevalence risks and incidents are evaluated and analysed to reduce risks and improve clinical care. Staff said it was challenging to deliver safe and effective care in the service. Staff did not demonstrate effective strategies are used to mitigate risks to consumers.

In response to the site audit report the approved provider advised;

* A trending analysis for falls is being conducted weekly and will be subject to monthly audit.
* Clinical management are reviewing all incidents as part of their daily routine. A response audit schedule has been drafted and implemented.
* A monthly infection related incidents audit and analysis will be implemented by clinical management.

While acknowledging actions taken by the provider following the site audit, after considering the information in the site report and the providers response, I am not satisfied the service is ensuring high impact, high prevalence risks are being effectively managed for consumers.

I therefore find Requirement 3(3)(b) Non-Compliant.

Requirement 3(3)(d)

Some consumers and representatives said the service has not identified and responded when consumers have deteriorated or following incidents.

A review of care documentation indicated action had not been taken following incidents or deterioration in the condition of some consumers. For example, a consumer in the MSU was reviewed by a Medical Officer (MO) on 11 September 2023 who raised concern about her swollen legs. On 12 September, the consumer had an episode when they became unresponsive, and the MO identified a need for ‘urgent review’. However, there was no evidence of further medical review, pain assessment or monitoring until the consumer demonstrated challenging behaviours on 14 September at which time ambulance assistance was requested.

Staff were unable to describe how they monitor consumers for signs of deterioration other than through clinical incidents. Due to a lack of clinical oversight and monitoring of consumers’ care documentation, changes in consumers’ condition were not identified or addressed in a timely manner.

In response to the site audit report the approved provider advised daily review by clinical management is being undertaken for consumers who have returned from hospital or have experienced a change of condition. Weekly audits will be conducted by clinical management.

After considering the information in the site report and the providers response, I am not satisfied staff are recognising and responding to changes in the condition of consumers which might indicate deterioration. Furthermore, the lack of oversight regarding clinical documentation also appears to be inhibiting the ability of staff to respond to changes in consumers’ condition. I acknowledge the actions taken by the provider to address issues concerning clinical oversight, but these will take time to be embedded in regular practice.

I therefore find Requirement 3(3)(d) Non-Compliant.

Requirement 3(3)(e)

Following an Assessment Contact conducted 14 June 2023 and 15 June 2023 the service was found Non-Compliant in Requirement 3(3)(e). Deficiencies related to;

* Care documentation did not demonstrate consumers’ condition, needs and preferences were documented in the consumer’s planning of care and communicated with staff where responsibility of care was shared.

Information in the site report indicated the previous deficiency has not been rectified. A review of care documentation identified gaps where recommendations from specialist services, discharge summaries and representatives had not been updated in consumer care plans.

For example, a review of care documentation identified at least three consumers who had been reviewed by external dementia specialists did not have their BSPs updated with the information. In another example, a consumer reviewed by a wound specialist did not have the recommended treatment commenced for 20 days.

Management acknowledged most care plans had not been reviewed or updated due to time constraints.

In their response the approved provider advised these issues will be addressed via clinical care needs audits.

After consideration of the information in the site report and the provider’s response, I am not satisfied the service is ensuring information about consumers’ conditions and treatment is being effectively documented and communicated within the organisation, based upon evidence and examples where information has not been transmitted.

I therefore find Requirement 3(3)(e) Non-Compliant.

I have decided the remaining Requirements of Standard 3 are Compliant as;

Consumers and representatives said they felt confident in the service’s ability to manage consumers’ end of life needs and wishes. Staff could describe how they support consumers at the end-of-life stage to ensure their comfort and dignity.

The service had a network of approved individuals, organisations, and providers they referred consumers to. Care planning documents reflected referrals to other health professionals were timely and staff understood the process to refer matters to other providers. Consumers confirmed referrals were made in a timely manner and in consultation with the consumer.

The service has an outbreak management plan, policies, and procedures to guide staff in infection prevention and control, and antibiotic management. The service has appointed an infection prevention and control lead who conducts weekly staff training on infection control practices and the use of personal protective equipment. Infections are reported, analysed, and reviewed via monthly reports.

# 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. | Not 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 has been found Non-Compliant as one of seven Requirements have been found Non-Compliant. The non-compliance is related to the following:

* The service is not demonstrating consumers are being provided services and supports for daily living to participate in their community, maintain relationships and do things of interest to them.

I have made this decision based on the following analysis.

Requirement 4(3)(c)

Consumers and representatives said there were not enough activities available within the service and said consumers do not receive enough assistance to attend activities on offer. This feedback was consistent in relation to consumers within the MSU.

A review of 15 consumers’ care documentation identified no leisure care plans had been developed for any of the consumers to determine what activities are of interest to them.

Lifestyle staff said there are no activities provided across the service on weekends and there are no lifestyle staff in the MSU and no set activities for consumers in the MSU.

Consumers were observed on a number of occasions to be congregated in the communal area of the MSU, without being engaged in any activities and with limited interaction with staff.

In responding to the Site audit report and Assessment Team feedback, the approved provider advised;

* Contrary to the site report, one lifestyle officer is allocated to the MSU Monday to Thursday and another one is being recruited.
* Activities on the weekend will be developed with the new lifestyle officer.
* Resources for the MSU lifestyle activities have been increased.
* The service is developing allied health leisure assessments for consumers.

Having considered the information in the site audit report and the approved provider response, I have decided that Requirement 4(3(c) is non-compliant as the service is unable to demonstrate that consumers are currently receiving support to engage in activities of interest within the service or maintain and develop relationships.

I find the other 6 Requirements of Standard 4 Compliant as:

Consumers and representatives said consumers are provided with effective services and supports to promote their well-being, independence, and quality of life. Consumers and representatives provided examples of being assisted by staff and supported by the service to maintain their independence. Staff and care documentation demonstrated awareness of supports required by consumers to promote their well-being.

Overall, consumers and representatives said the service provides emotional, spiritual, and psychological support to consumers when needed. Care planning documentation identified information regarding the emotional, spiritual, and psychological needs of individual consumers, however, in some cases this information was incomplete. The organisation engages a Pastor who provides consumers with one-on-one support. Staff were aware of consumers’ religious preferences.

Most consumer’s needs, goals and preferences were communicated effectively across the service and with others who have care responsibility. Consumers and representatives said staff know their individual preferences and other organisations that may be involved in their care and services. Staff described how they are updated on the changing condition, needs or preferences of consumers as they relate to services and supports for daily living via staff handover, However, management acknowledged that care plans are overdue for review and outlined a plan to update these by the end of November 2023.

Staff were able to describe how the service partners with and organises referrals to various individuals and providers. Consumers expressed satisfaction with referral arrangements made on their behalf as required.

Most consumers and representatives spoke highly of the food and said the meals are satisfying, varied and of suitable quality and quantity. Consumers have input into the menu through monthly consumer meetings and food focus groups. Care planning documentation identified dietary needs and preferences for consumers.

Consumers reported having access to equipment, including mobility aids and wheelchairs which are safe, and they were aware of how to report any issues with equipment. The service has processes for purchasing, servicing, and replacing equipment. Equipment used to support consumers was observed to be suitable, clean, and well-maintained.

# 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. | Not 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 |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Quality Standard has been found Non-Compliant as two of three Requirements have been found Non-Compliant. The non-compliance is related to the following:

* The service was unable to demonstrate the environment is well designed and welcoming to consumers and their visitors.
* Consumers were unable to freely move around the service both indoors and outdoors.

I have made this decision based on the following analysis.

Requirement 5(3)(a)

Consumers and representatives of consumers in the MSU said the service environment was not welcoming, did not encourage a sense of belonging and lacked private spaces for visitors. Representatives complained of malodour in the MSU.

Staff acknowledged the lack of private sitting areas in the MSU and said they did not have time to walk consumers around the service environment due to the number of consumers with challenging behaviours and staffing restraints.

Consumers were observed being left to sit in the communal area of the MSU or laying in their beds during the first day of the site audit.

In response to the site report, the approved provider advised;

* The door to the secure outdoor area of the MSU is now opened daily to support movement around the unit.
* Additional improvements in the area have been made or are planned, including improved fencing, a sensory garden, raised gardening beds and an outdoor activity board.
* The communal area in the MSU is being redesigned to create more dementia friendly, welcoming, and homely spaces.

I welcome and acknowledge the actions being planned and implemented by the provider to improve the environment in the MSU. However, such actions will take time to be fully implemented and evaluated and after considering the information in the site report and the response I have decided Requirement 5(3)(a) is Non-Compliant, based on the feedback from consumers and representatives that the service environment was unwelcoming, as well as descriptions of malodour and a lack of spaces to encourage independence and interaction.

Requirement 5(3)(b)

Consumers and representatives raised concerns that consumers in the MSU were unable to access the outdoor area. Representatives said the doors to the outdoor area were locked or rarely open.

The Assessment Team noted the doors to the outdoor area were closed on the first day of the site audit. After providing feedback to management, the doors were opened for the remaining two days of the site audit to positive response from consumers and representatives.

The site audit report indicated staff said they had been instructed to keep the doors to the outdoor area closed as a safety strategy to prevent falls. Management confirmed this, but indicated they would explore other strategies to prevent falls while opening the doors to the outdoor area of the MSU. Staff also said consumers were unable to leave the MSU area as there were not enough staff to monitor their movements.

In responding to the Site report, the approved provider said the doors to the outdoor area of the MSU are now open daily and the internal doors are no longer locked.

After considering the information in the site report and the approved provider response I have decided Requirement 5(3)(b) is Non-Compliant, as the evidence before me is that consumers in the MSU were not able to move freely around the service or have access to outdoor areas. The changes implemented by the provider are welcomed and will need to be reassessed.

I find Requirement 5(3)(c) Compliant as the service was able to demonstrate furniture, fittings and equipment in the service environment was safe, clean, and well maintained. Consumers said they were satisfied with cleaning of their rooms and the service environment. The service evidenced effective regimens for both proactive and reactive maintenance.

# 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

This Quality Standard has been found Compliant as four of four requirements have been found Compliant.

Consumers and representatives were comfortable providing feedback and raising concerns and expressed confidence that the service would address and resolve any problems formally raised. Consumers and representatives could describe the various methods available to raise concerns including speaking to management or staff directly, during consumer meetings, and using feedback forms.

Consumers and representatives said they are aware of advocacy and language services available to them and referenced the promotional material displayed at the service. Staff said they would support consumers in raising feedback by communicating concerns to management on the consumers’ behalf or assisting consumers in completing feedback forms as required. Staff described how they would manage any concerns on behalf of a consumer where possible and escalate to the management team if they could not resolve an issue.

Management and staff demonstrated a shared understanding of processes to follow when a complaint is received and of open disclosure principles. The service had policies and procedures on feedback and complaints management, and open disclosure. Staff are guided on how to document, investigate, resolve, and evaluate feedback and complaints.

Management advised the service trends and analyses complaints and feedback and uses this information to inform continuous improvement activities which are documented under the service’s plan for continuous improvement. Consumers and representatives expressed confidence in the service utilising feedback to make improvements, and review of the service’s plan for continuous improvement reflected this.

# 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)(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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

This Quality Standard has been found Non-Compliant as three of five Requirements have been found Non-Compliant. The non-compliance is related to the following:

* The service was unable to demonstrate the workforce is planned to enable to delivery and management of safe and quality care and services.
* The service was unable to demonstrate the workforce is competent and have the knowledge to effectively perform their roles and responsibilities.
* The service was unable to demonstrate workforce performance is regularly assessed, monitored, and reviewed.

I have made this decision based on the following analysis.

Requirement 7(3)(a)

Following an Assessment Contact conducted 14 June 2023 and 15 June 2023 the service was found Non-Compliant in Requirement and 7(3)(a). Deficiencies related to;

* The service being unable to demonstrate the workforce was able to deliver safe and quality care due to vacant senior clinical positions and high numbers of inexperienced staff.

Information from the site report indicated that staffing levels in the MSU were insufficient. Staff said there were generally not enough staff to support the cohort of consumers due to the high number of 2 assist consumers. As a result of this, consumers were often left unsupervised leading to falls and other incidents such as episodes of incontinence as consumers were having to wait until staff became available.

It was reported that there are currently no lifestyle staff rostered on to the MSU, resulting in a lack of activities for consumers within the area, however, this was disputed by the provider in their response.

Clinical care staff said they did not have enough time to complete their work, citing examples relating to documentation related to restrictive practices, BSPs and incident management.

The Assessment Team review of staffing allocations indicated the staffing model for the MSU is not being met on a regular basis, resulting in adverse outcomes such as consumers not being able to access the outdoor area as there is not enough staff to supervise them. Review of rostering information indicated that the MSU is not fully staffed approximately 50% of the time.

In response to the site report the approved provider advised the service’s master roster hours satisfy the assessed mandatory hours. They also advised daily staffing outcomes are dependent upon unplanned leave and access to available existing or agency staff.

Having considered the information in the site audit report and the approved provider response, I have decided that Requirement 7(3(a) is Non-Compliant as the evidence (including staff testimony) indicates staffing deficiencies are having adverse impacts upon consumer care in the MSU.

Requirement 7(3)(c)

Information in the site report indicated the service is unable to demonstrate the workforce have the knowledge to effectively perform their roles. For example, staff interviewed said they struggle to manage consumers’ behaviours and would like additional training in managing challenging behaviours.

Interviews with registered staff identified they do not have a common understanding of restrictive practices or the falls management process. Clinical management confirmed this to be the case. Clinical management also acknowledged they do not have a full knowledge of reportable incident requirements.

Care staff raised concerns that due to staffing shortages resulting in staff rushing to perform tasks, they had witnessed unsafe work practices and were concerned about unsafe manual handling processes.

Review of care documentation identified neurological observations are not consistently conducted on consumers who had falls.

In response to the site report the approved provider advised clinical staff are being retrained in SIRS reporting and restrictive practices. The importance of adhering to safe manual handling processes has been reinforced with staff with observations regarding manual handling being increased.

Having considered the information in the site audit report and the approved provider response, and acknowledging actions being undertaken by the provider, I have decided that Requirement 7(3(c) is Non-Compliant as staff have admitted to lacking the knowledge required to perform their roles and care documentation is not being completed to the degree of competence required.

Requirement 7(3)(e)

Information in the site report indicated the service was not regularly assessing, monitoring, or reviewing staff performance.

Staff interviews indicated most staff had not received a staff performance assessment within the last year and sometimes longer.

While the service was able to demonstrate an effective onboarding process for new staff, it was acknowledged the service does not have an active performance appraisal system for existing staff and no schedule recording when staff do have performance assessments.

Clinical management said there was no oversight by the organisation of their performance.

In response to the site report, the approved provider advised staff are undertaking self-appraisals in preparation for staff performance assessments yet to be scheduled. The service is working to develop a positive culture regarding self-reflection and peer appraisal.

Having considered the information in the site audit report and the approved provider response, I have decided that Requirement 7(3(e) is Non-Compliant as the service is currently unable to demonstrate assessments and appraisals of staff performance are occurring.

I find Requirement 7(3)(b) Compliant as consumers and representatives considered consumers are treated kindly and with respect. Staff were observed assisting consumers in a considerate manner and speaking to consumers in a kind and caring manner. Management advised they monitor staff behaviour through complaints and feedback.

I find Requirement 7(3)(d) Compliant as consumers and representatives were satisfied staff are recruited and trained to provide safe and effective care. Consumers and representatives expressed confidence that staff knew what they were doing. The service was able to demonstrate staff have the appropriate qualifications to perform their roles and that induction, education and mandatory training of staff is occurring. The annual training program includes topics mandatory for all staff such as manual handling and infection control (COVID), with other non-mandatory topics including basics of documentation and understanding sepsis and septic shock. Staff said they were able to provide feedback to management regarding their support and improvement needs.

# 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. | 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. | Not 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. | Not Compliant |

Findings

This Quality Standard has been found Non-Compliant as four of five Requirements have been found Non-Compliant. The non-compliance is related to the following:

* The service was unable to demonstrate a culture of safe, inclusive, and quality care and services with monitoring process to effectively provide safe services relating to care delivery.
* Organisation wide governance systems relating to information management, continuous improvement, workforce capability and regulatory compliance.
* Providing an effective risk management system to identify, review and action risks to the benefit of consumers.
* The service was unable to demonstrate the organisation’s clinical governance framework monitors the systems required to maintain and improve reliable, safe, and quality care for consumers.

Requirement 8(3)(b)

Information in the site report indicated the service’s governing body has not been able to demonstrate accountability for the delivery of safe, inclusive, and quality care and services.

The site report indicates the organisations electronic information system is not used to support staff in identifying information of importance. For example, it was identified that hyperlinks to information within the system do not open most of the time.

The organisations incident management system is not identifying incidents that are reportable under SIRS. The Assessment Team identified 11 incidents involving consumers relating to aggressive behaviour and missed medications which should have been reported under SIRS.

Operational reports have failed to inform the service’s governing body of the inadequacy of staffing for the MSU. As discussed under Requirement 7(3)(a), staffing records show the MSU is not fully staffed approximately 50% of the time. A clinical audit conducted once per year does not support continuous monitoring of the performance of the service.

In response to the site report the approved provider advised monthly clinical indicator reports are submitted to the board, service managers submit a weekly written report to the CEO and the service will maintain onsite fortnightly management meetings with the service management and board representatives. These measures were noted to be in progress in the services Plan for Continuous Improvement (PCI).

Having considered the information in the site audit report and the approved provider response, I have decided that Requirement 8(3(b) is Non-Compliant as the evidence shows the current reporting systems are not working to promote a culture of safe, inclusive, and quality care.

Requirement 8(3)(c)

The site report indicates ineffective organisation wide governance systems in relation to information management, continuous improvement, workforce governance and regulatory compliance.

Management reported that information to guide staff practice relating to care plans and BSPs is not accurate as the plans have not all been reviewed for currency and accuracy. As discussed in other sections of this report, information management systems are also ineffective with respect to staffing issues, incident reporting, and policies and procedures.

While the organisation has established a continuous improvement system, the Assessment Team identified the system is not used effectively to document, monitor, and evaluate improvements. For example, the service’s PCI was not reviewed regularly and contained action completion dates which have passed without the action having been completed or reviewed.

Workforce governance systems do not monitor and 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. Attempts to increase staffing levels have not been evaluated for effectiveness.

With regards to regulatory compliance, the service has systems to monitor changes in aged care legislation and responsibilities, however, the service could not demonstrate effective monitoring of regulatory responsibilities is occurring at the service level in relation to SIRS reporting and obligations or in relation to restrictive practices and their responsibilities.

The site report indicates the organisation does have effective governance systems with respect to financial governance and feedback and complaints.

In their response the approved provider advised;

* Policies and procedures are to be reviewed by the Group Manager
* An audit schedule has been developed to feed into reporting process and inform continuous improvement within the service.
* Management has developed an incident flow chart that specifies responsibility for each part of the process and incidents analysis is taking place.
* A feedback and complaints analysis will take place monthly.

Having considered the information in the site report and the provider response, I am not satisfied the service has effective organisation wide governance systems due to evidence the systems in place at the time of the site audit were ineffective. I note some actions proposed by the provider are still in process and it will take some time for systems to be brought back to a level that supports service compliance with the Quality Standards.

I therefore find Requirement 8(3)(c) Non-compliant.

Requirement 8(3)(d)

The site report indicated the service’s risk management system is currently ineffective. For example, consumers who experience pain are not provided with medication or treatment in a timely manner and consumers with behaviours do not have individualised reviews completed post incident to evaluate the effectiveness of their BSP.

Not all incidents were reported and those that were reported were not analysed to identify the risks associated with the care for the consumers affected.

Management advised they do not have enough time to review all incidents that occur in the MSU and staff there said they don’t always have time to document incidents.

In the response to the site report the approved provider advised a detailed master risk register has been designed and implemented to capture the core risks within the facility. This also includes care plan review and ensuring better management oversight of care plan updating.

Having considered the information in the site report and the provider response, I am not satisfied the service has an effective risk management system and practices as reporting of incidents is not consistent, and incidents appear to not to have been investigated or evaluated to prevent further incidents.

I therefore find Requirement 8(3)(d) Non-Compliant.

Requirement 8(3)(e)

The site report indicated that while the service has a clinical governance framework and staff are familiar with, and implementing, antimicrobial stewardship and open disclosure principles, the service was not able to demonstrate effective mechanisms and systems to minimise the use of restraint and manage incidents.

Consumers who experience pain and falls are not adequately assessed in a timely manner and neurological observations are often not completed for consumers who do fall as per the service’s falls management policy.

Management was unable to provide examples of how the service is endeavouring to minimise the use of restrictive practice. A review of consumer’s care documentation evidenced chemical restraint is sometimes used as a first response to managing consumer’s behaviour and did not demonstrate attempts to minimise the use of chemical restraint.

In responding to the site audit report the approved provider advised a clinical management report is currently being completed weekly. It will be revised to ensure it meets the requirements of senior management and the board.

Having considered the information in the site report and the provider response, I am not satisfied the service has an effective clinical governance framework as the service was unable to demonstrate the framework is helping staff to minimise the use of restrictive practices or ensure best practice clinical care for consumers.

I therefore find Requirement 8(3)(e) Non-Compliant.

I find Requirement 8(3)(a) Compliant as consumers and representatives said they felt they can provide feedback and suggestions to management through multiple forums, and they provided examples regarding laundry service and food where their feedback led to changes in the service. Management described various ways consumers are supported to be engaged in the development, delivery and evaluation of care and services, including via monthly consumer/representative and food focus meetings.

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