Performance

Report

1800 951 822

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Performance report date: |
| Moyne Aged Care Plus Centre | 9 September 2022 |
| Commission ID: | Activity type: |
| 2519 | Site audit |
| Approved provider: | Activity date: |
| The Salvation Army (NSW) Property Trust | 19 July 2022 to 26 July 2022 |

This Performance Report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This Performance Report**

This Performance Report for Moyne Aged Care Plus Centre (**the service**) has been considered by Therese Solomon, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit, the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Assessment Team’s report received 30 August 2022.
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: 11 Consumers and 4 representatives provided feedback to the Assessment Team.
* the following information received from the Secretary of the Department of Health (**the Secretary**): Exceptional Circumstances Determination dated 08 April 2021.

# Assessment summary

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

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

# Areas for improvement

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

### Requirement 1(3)(a)

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

The approved provider must demonstrate:

* Consumers are treated with dignity and respect, and that consumers are spoken about in dignified language.

### Requirement 1(3)(f)

*Each consumer’s privacy is respected and personal information is kept confidential.*

The approved provider must demonstrate:

* Consumers’ personal information is kept private and confidential. Personal files must be kept in secure areas with access restricted to staff.

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

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The approved provider must demonstrate:

* Assessment and planning identify and considers risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services.
* The service has implemented all continuous improvement actions identified in their response.

### Requirement 2(3)(b)

### *Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

### The approved provider must demonstrate:

* Assessment and planning consistently addresses the needs, goals and preferences of consumers, including advanced care planning and end of life planning if the consumer wishes.
* Assessment and planning includes consideration of consumer goals and preferences and embodies a holistic approach.

### 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.*

The approved provider must demonstrate:

* Assessment and planning is based on ongoing partnership with the consumer and others that the consumer wishes to involve, including other organisations, individuals and providers of other care and services.

**Requirement 2(3)(d)**

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The approved provider must demonstrate:

* Consumer care plans are effective to guide staff in the delivery of safe and effective care to meet consumer needs, goals and preferences.
* The outcomes of assessment and planning are effectively communicated to the consumer and/or their representative.
* The service has systems in place to inform consumers that they can access their care and services plan and how to request it.

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The approved provider must demonstrate:

* Care and services are reviewed for effectiveness when circumstances change or incidents impact on the needs, goals or preferences of the consumer.
* The review of care and services are done in collaboration with the consumer/representative.

**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.*

The approved provider must demonstrate:

* Consumer clinical and personal care is best practice, tailored to the consumer’s needs and optimises their health and well-being, including in the areas of restrictive practices, wound management, pain management, diabetes and fluid management.
* All improvements relating to personal and clinical care are applied in practice consistently.
* That the service has a comprehensive understanding of restrictive practices and legislative requirements.

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

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The approved provider must demonstrate:

* The high impact or high prevalence risks associated with the care of consumers are effectively identified and managed, including in the areas of pressure injuries, falls, unplanned weight loss and behaviour management.
* Interventions to minimise high impact and high prevalence risks are reviewed for effectiveness.

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

The approved provider must demonstrate:

* The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved, and care planning includes a palliative care plan addressing any end of life care interventions.

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The approved provider must demonstrate:

* Deterioration or change of a consumer’s condition is recognised and responded to in a timely manner by the service.
* Deterioration or change of a consumer’s condition is communicated to the consumer/representative.

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

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

The approved provider must demonstrate:

* Information about the consumer’s condition, needs and preferences is documented effectively to ensure it is communicated to staff and others responsible for the consumer’s care.
* There is review and improvement of all information systems to ensure they are accurate and current.

### Requirement 3(3)(f)

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

The approved provider must demonstrate:

* Consumers are referred to appropriate individuals, other organisations or providers of other care and services in a timely manner.

### 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.*

The approved provider must demonstrate:

* There are standard and transmission-based precautions to prevent and control infections.
* There are effective practices to promote appropriate antibiotic prescribing and use to support optimal care.
* There are effective systems for managing a potential COVID-19 outbreak.
* There are effective staff practices to promote infection control and antimicrobial stewardship.
* The service has implemented all continuous improvement actions identified in their response.

**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.*

The approved provider must demonstrate:

* 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.
* All consumers regardless of their mobility status have the opportunity to engage in activities of meaning.

### 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.*

The approved provider must demonstrate:

* Services and supports for daily living assist each consumer to do the things of interest to them, regardless of their mobility status.

### 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.*

The approved provider must demonstrate:

* Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

### Requirement 4(3)(f)

*Where meals are provided, they are varied and of suitable quality and quantity.*

The approved provider must demonstrate:

* Clear and effective communication between departments to ensure meals provided are suitable for consumers and meet their assessed needs.

### Requirement 4(3)(g)

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

The approved provider must demonstrate:

* Where equipment is provided, it is safe, suitable, clean and well maintained.

### 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.*

The approved provider must demonstrate:

* The service is easy to understand and navigated, and that the environment does not impacts on consumers independence, interaction and function.

### 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.*

The approved provider must demonstrate:

* The service environment is safe, clean and well maintained.
* The service environment allows all consumers to move freely inside and outside the service.
* Maintenance issues are consistently reported and actioned.

### Requirement 5(3)(c)

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

The approved provider must demonstrate:

* Where equipment is provided, it is safe, suitable, clean and well maintained.

**Requirement 6(3)(b)**

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

The approved provider must demonstrate:

* Consumers/representatives and all staff are aware of any external methods to assist with complaints/feedback or how they escalate issues or concerns outside of the service.

**Requirement 6(3)(d)**

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The approved provider must demonstrate:

* Feedback and complaints are recorded and effectively reviewed and analysed to improve the quality of care and services.
* Consumer and representative feedback informs continuous improvement actions for the service.

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

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The approved provider must demonstrate:

* The number and mix of staff members enable the delivery and management of safe and quality care and services.
* Adequate staffing levels to support consumer care and services.

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

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The approved provider must demonstrate:

* That the workforce is competent to effectively perform their roles through ongoing assessment of staff performance and completing staff reviews.

### Requirement 7(3)(d)

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The approved provider must demonstrate:

* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality standards.
* Ongoing training is provided to the staff relevant to their roles.
* Mandatory training is completed within required timeframes.

### Requirement 7(3)(e)

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The approved provider must demonstrate:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Review and improvement of the performance review process.

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

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

The approved provider must demonstrate:

* Consumers are actively engaged and supported in the development, delivery and evaluation of care and services.
* Consumer feedback influences the development, delivery and evaluation of care and services, across the service and organisation.

### Requirement 8(3)(b)

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

The approved provider must demonstrate:

* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery*.*

**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.*

The approved provider must demonstrate:

* The organisation wide governance systems implemented at the service are effective. This includes in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

**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.*

The approved provider must demonstrate:

* The service has implemented effective risk management systems and practices to manage the high impact or high prevalence risks associated with the care of consumers, to identify and respond to abuse and neglect of consumers, and to support consumers to live the best life they can.
* The service has an effective incident management system to manage and prevent incidents.

**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.*

The approved provider must demonstrate:

* The clinical governance framework implemented at the service is effective in ensuring safe and effective clinical care, minimising the use of restraint, appropriate use of antibiotics, and that open disclosure is consistently used in response to complaints and incidents.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | | Non-compliant |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-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. | Non-compliant |

## Findings

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

Consumers and representatives reported that the service offers care and services that are culturally safe for each consumer. They stated they feel included regardless of their backgrounds which makes each consumer get the care and services that are safe for them and consumers and representatives were able to demonstrate how staff value their diversity and respected their individual cultures.

Overall, consumers and representatives were able to make decisions about their care and service delivery. Staff interviewed were aware of consumers’ preferences, and this was supported by care documentation.

The service was able to demonstrate that consumers are able to maintain relationships of their choice. Some consumers requested female only staff for personal hygiene, this has been respected by the service and staff ensure that a female staff member attend their needs.

Staff interviewed were aware of consumers preferences and care staff could explain how they assist consumers to maintain relationships that are important to them.

The Assessment Team found that consumers are able to take risks to ensure they can live their best life while at the service, however the Assessment Team was unable to find supporting documents outlining the risk to the consumers. The service was unable to demonstrate that the consumers and representatives understood the risks they chose and how it could impact on their lives.

The Assessment Team noted that the service was not completing risk assessments in a timely manner or keeping them up to date.

Consumers, representatives and staff where able to describe effective communication. Where representatives have requested to be notified of any changes regardless of the time, the service has demonstrated they have done this.

Staff explained how they take time and offer multiple different avenues to ensure information is passed onto the consumer and representative in a timely manner. Staff reported they utilise multiple methods of communication that includes hard copies, soft copies and reading the information to the consumer where they have cognitive impairments.

**The following four requirements were found to be non-compliant.**

### Requirement 1(3)(a) Non-compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

Consumers and representatives interviewed stated they are treated with respect and dignity by staff being polite, asking questions and doing things for them when they ask them.

Care staff were observed greeting consumers in a bright and cheerful way and consumers responded in a positive manner. However, observations made by the Assessment Team of consumers and how they were presented did not always indicate that consumers were treated with dignity and respect.

Consumers and representatives stated they have to wait a long time to be attended to when they push the call bell for assistance.

The Assessment Team observed staff referring to consumers in undignified terminology or using undignified language when explaining consumers to the Assessment Team.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on dignity and respect, education and training for staff on cultural safety, education for all staff on customer service.

The evidence compiled at the site audit shows the service was unable to demonstrate that each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-Compliant.

### Requirement 1(3)(f) Non-compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

While consumers and representatives felt that each consumers’ personal privacy was respected, the Assessment Team observed staff interactions that were not always dignified, or respectful of each consumer’s privacy.

The service was unable to demonstrate that they keep personal information private. There were several occasions where the service was witnessed leaving doors open to the nurses’ station where personal information was kept. Furthermore, it was also demonstrated where staff were openly discussing personal consumer information within a communal area with other consumers in immediate proximity.

Although staff could demonstrate an understanding of consumers’ personal privacy while providing personal care and hygiene, only senior staff were able to explain how to keep personal information private, through the use of individual logins and signing out of the electronic documentation system.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all registered nurses and key staff members on information management, education for staff on privacy and confidentiality, training on how to keep personal information private, how to use individual logins, and signing out of the electronic documentation system.

The evidence compiled at the site audit shows the service was unable to demonstrate that each consumer’s privacy is respected, and personal information is kept confidential.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

# Standard 2

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

## Findings

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

### Requirement 2(3)(a) Not Met

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team found that assessment and planning, including consideration of risks to consumers’ health and well-being, is not consistently effective in informing the delivery of safe and effective care and services.

The Assessment Team identified that consumers who experience pain, behavioural challenges, and falls are not consistently assessed to manage the risks and that care plans do not reflect appropriate and timely assessment.

Consumers and representatives stated they are not involved in the assessment and planning of their personal and clinical care.

Consumers’ care planning documentation demonstrates some risks to consumers health and well-being are identified and documented in their care plan however assessment and planning does not always reflect actual risks. Clinical risks such as falls, pain and behaviour are not assessed and planned effectively, and the Assessment Team identified areas for improvement in wound management.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all registered nurses on risk assessment, education on the pain management policy and procedure, education and training on wound management.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 2(3)(b) Non-compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

The Assessment Team found the service’s assessment and planning processes do not adequately address consumers’ needs, goals and preferences, and that end of life care plans were not provided for consumers who have recently been on a palliative pathway.

A review of care planning documentation identified information in consumers’ care plans do not reflect consumers’ current needs, goals and preferences. The service manager’s monitoring tool reports fourteen of twenty-nine consumers do not have advanced care directives.

Consumers and representatives stated they are satisfied with the way their care is delivered, however some consumers and representatives reported they don’t receive the personal hygiene they prefer.

Some staff could describe consumers’ requirements in terms of their physical needs, however not from the point of view of how consumers want their care provided

The Approved provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on partnership care planning, training to all registered nurses and care managers on partnership care planning across the end of life care pathway, provide training to all staff on person-centred care including inclusion of consumers during care planning to ensure the consumer’s choice is respected and documented.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 2(3)(c) Non-compliant

*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.*

The Assessment Team identified that assessment and planning is not always based on ongoing partnership with consumers and representatives or others they wish to be involved. Representatives are not always informed of changes to consumers’ condition and care planning documentation does not evidence ongoing partnership with consumers.

The service does not demonstrate recommendations from other providers of care are considered in assessment and planning for consumers.

The service manager stated they have identified a gap in the service’s implementation of this requirement. They stated they have recommenced a schedule for regular case conferences for consumers and whoever the consumer wishes to be involved. The Assessment Team reviewed the schedule which indicated nine of twenty-nine consumers have had a case conference.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on partnership care planning, training to all staff on person-centred care including inclusion of consumers during care planning to ensure the consumer’s choice is respected and documented, provide training to staff to ensure the consumer receives a copy of their care plan.

The evidence compiled at the site audit shows the service was unable to demonstrate assessment and planning is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and includes otherorganisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 2(3)(d) Non-compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The service does not demonstrate the outcomes of assessment and planning are effectively communicated to the consumer and representative in a care and services plan that is readily available to the consumer and where care and services are provided.

Permanent consumers have comprehensive care plans available to staff through the electronic documentation system. While management have plans to include provision of care plans to all consumers this has not yet occurred. Most consumers are not aware of their care plan and say they have not been offered a copy.

Management stated they are aware the service has not previously had a system to offer care plans to consumers and representatives. Management reported they have commenced a schedule of case conferencing where they will offer care plans to all consumers and/or their representatives.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; training to all staff on person-centred care, training to staff to ensure the consumer receives a copy of their care plan, training to all registered nursed and care managers on communication and reporting outcomes of assessments to consumers.

The evidence compiled at the site audit shows the service was unable to demonstrate that 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 2(3)(e) Non-compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The service demonstrates regular care plan reviews however the reviews do not always reflect consumers’ needs, goals and preferences. Care plans are not reviewed in a timely manner when changed circumstances and incidents impact consumers’ needs, goals and preferences.

The care manager showed the Assessment Team the doctors’ case conference schedules. Case conference review documentation identified the case conference is a health assessment from a medical perspective rather than a holistic review of consumers’ needs, goals and preferences.

The service manager reported they are in the process of commencing case conferences with all consumers and delegating responsibilities to registered nurses, however they do not yet have a permanent care manager and have only one permanent registered nurse.

The registered nurse who supports the service remotely stated they review care plans when they are due for the third monthly review and if changes occur. They said they review progress notes and incident reports through the electronic system and talk with staff when required to understand the consumers requirements. There is no clear system to involve consumers in the regular review of their care plans.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on person-centred care, implement incident management policy and procedure training to all staff.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

# Standard 3

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

## Findings

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

### Requirement 3(3)(a) Non-compliant

*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.*

While the organisation has policies which reflect best practice, staff practice does not align with the policies and procedures. Care planning documentation does not consistently reflect care is tailored to consumers’ needs, and consumers’ wound management, nutrition and hydration, continence management and pain management are not consistently reflective of the service’s policies and best practice.

The service does not demonstrate understanding of restrictive practices regarding chemical restraint. While the organisation has policies and procedures which are current and reflect legislative changes, the Assessment Team identified some areas of improvement regarding the management of psychotropic medication and chemical restraint.

Chemical restraint authorisations were reviewed by the Assessment Team indicating all consumers who are prescribed psychotropic medication have a chemical restraint authorisation form. Doctors and consumers/representatives signed the consent forms.

The form does not outline the associated risks, the ongoing review with consumers and representatives, using minimal doses and reducing doses where possible. The reasons a consumer is taking the medication are not documented on the form.

The Assessment Team identified the organisation has a new detailed restrictive practices authorisation form, stored with the policies, however the service is currently not using this form.

Consumers who have bedrails do not have a risk assessment identifying the risks associated with the bedrail use.

The service does not demonstrate consumers skin integrity is monitored and managed appropriately. Consumers identified as being at risk of pressure injuries are not monitored and wounds are not managed evidencing best practice.

The service does not demonstrate comprehensive pain management for consumers. Pain monitoring charts are mostly completed when consumers complain of pain and are not attended regularly to gain a comprehensive picture of consumers’ pain and best management strategies. Consumers were observed expressing pain on multiple occasions at the nurses’ station.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; implement a skin integrity program, provide training to all registered nurses on restrictive practices management with a focus on psychotropic medication management, implement training to all staff on medication management policy and procedure, provide training to all registered nursed on pain management policy and procedure.

The evidence compiled at the site audit shows the service was unable to demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 3(3)(b) Non-compliant

*Effective management of high impact or high prevalence risks associated with the care of each* consumer.

The service records and tracks consumers with high impact or high prevalence risks, however the Assessment Team finds these risks are not effectively managed. The management team reported they plan on reviewing these consumers and the risks at monthly clinical meetings, but the program is new and has not yet had time to be fully evaluated for effectiveness.

The Assessment team identified that clinical monitoring is not effective in identifying and managing consumers’ risks. Consumers identified as being affected are consumers who experience pain, exhibit behaviours, have complex nursing needs and/or receive medication.

Staff described consumers’ behaviours in a way that indicated they do not have understanding of dementia or person-centred behaviour management. One care staff member was able to describe each consumer’s most significant clinical and /or personal risks however other care staff who work for an agency said they do are not involved in discussion regarding behaviour management for consumers.

The management team stated they are working through a program to ensure all consumers who are prescribed psychotropic medication or have behaviours of concern have a behaviour support plan. Behaviour support plans reviewed did not include personalised details of consumers’ behaviour management strategies, or evidence of consultation with consumers and representatives.

The Assessment Team reviewed a missed medication report which includes multiple missed medications each day across the two co-located services. Management were unable to explain the report. The missed medications have not been investigated.

The care manager stated they have not been trained on how to use the clinical reporting section of the electronic care documentation system. They are not able to review medication reports such as missed medications or PRN usage. The service manager said this is done manually.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all registered nurses on risk assessment, provide training to all registered nurses on restrictive practices management, including utilizing the detailed restrictive practices documentation, provide training to registered nurses on medication management, pain management and wound management.

The evidence compiled at the site audit shows the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 3(3)(c) Non-compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

The organisation has a comprehensive end of life procedure and pathway which includes collaboration with consumers and families to maximise choice, comfort and dignity at the end of life. An end of life pathway document is included in the procedures which is to be used ‘as part of the consumer clinical documentation and is supplementary to the consumer care plan.

However, the Assessment Team identified that the service does not always demonstrate the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

While the organisation has an end of life pathway the Assessment Team finds this is not consistently utilised for consumers with expected end of life requirements and anticipatory care needs are not addressed in a timely manner.

Most consumers’ files had advanced care directives. However, the Assessment Team identified a consumer who did not have an advanced care directive and found no evidence of collaborative consultation the consumer and representative to discuss end of life choices and management strategies.

The Approved Provider responded to the Assessment Team’s report did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all registered nurses and care managers on the end of life care pathway, provide training to all staff on partnership care planning, provide training to all registered nursed on care of the deteriorating consumer, provide training to staff on person-centred.

The evidence compiled at the site audit shows the service was unable to demonstrate the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 3(3)(d) Non-compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The service does not demonstrate 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.

Information regarding consumers’ deterioration or change is not effectively shared with staff or the consumers’ chosen representatives. Clinical monitoring processes are inconsistent, and staff are not all aware of the organisation’s procedures for recognising deterioration in consumers’ physical, cognitive or mental health.

Reviewed care planning documentation did not consistently reflect identification of or response to deterioration or changes in consumer function, capacity or condition. Monitoring of consumers’ clinical condition following incidents is not always attended.

The organisation has policies and procedures in place for supporting staff to recognise and respond to deterioration or changes in a consumer’s condition, however staff practice does not always align with the policies and procedures.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on care of the deteriorating consumer, including management and completion of documentation, education to registered nursed on timely referrals to other services as needed, provide training to registered nurses on medication management, pain management, falls and wound management.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 3(3)(e) Non-compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

The Assessment Team found information about consumers’ condition, needs and preferences is not consistently documented and communicated within the organisation and with others where responsibility is shared.

The Assessment Team found information about consumers’ condition, needs and preferences is not consistently documented and communicated within the organisation and with others where responsibility is shared.

Each consumer has a care plan which outlines ‘observations, goals and interventions’ for each care domain. While there is evidence that some consumers’ condition, needs and preferences are documented, the electronic documentation system does not prompt staff to document these.

Staff handovers are not effective in informing staff of key information to manage consumers’ clinical and personal needs and preferences. Care plans do not always contain accurate and current information. These deficits impacted consumers including those with changed behaviours, wounds or who experience falls.

Generally, consumers reported that regular staff are aware of their requirements however some reported there are many changes in staff and new or agency staff do not know what their personal and clinical care requirements are.

Staff stated they do not always find out consumers’ needs at handovers, and allied health staff reported they do not always know what is happening with consumers as the registered nurses are changing all the time.

The care manager stated that consumers’ key clinical information such as when pain patches or catheters are due to be changed is documented on a white board in the nurses’ station. They stated it is frustrating as often the information does not align with what is in the electronic care plan or medication chart. This was discussed with management who said they would review the use of the white board.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all registered nurses and care managers on communication, provide training to all staff on how to use the electronic care documentation system.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 3(3)(f) Non-compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

While the organisation has systems to refer consumers to individuals, other organisations and providers of other care and services, the Assessment Team found this does not always occur appropriately. Review of consumers’ care and services demonstrates referrals are not always timely and appropriate.

Most consumers reported they have access to their doctors and allied health professionals.

The Assessment Team identified that recommendations from other providers of care are not always incorporated into consumers care planning.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on communication, training to all registered staff on partnership care planning and include appropriate referrals to specialist agencies and practitioners where indicated.

The evidence compiled at the site audit shows the service was unable to demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 3(3)(g) Non-compliant

*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.*

The Assessment Team found that while the organisation has policies and procedures to guide staff in minimising infection related risks, the service does not demonstrate standard and transmission-based precautions to prevent and control infections. The service does not demonstrate practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The Assessment Team found that systems for managing a potential COVID-19 outbreak are disjointed and not known to staff. The Assessment Team identified issues in staff practices and staff training in infection control and antimicrobial stewardship. Risks were identified for all consumers residing at the service.

Management stated the service does not have a trained infection prevention and control lead. The area manager reported that the organisation is looking to train the manager and other suitable staff in the future.

When interviewed, staff were not aware of where the COVID-19 outbreak management plan is kept. This was discussed with the service manager during a phone call. This COVID-19 outbreak management plan was found by staff and reviewed by the Assessment Team.

The Assessment Team were advised that the person responsible for attending audits have not attended any infection control audits, but they do walk around and check to see if staff are wearing PPE correctly.

The Assessment Team identified a number of breaches in infection control measures during the site audit.

The organisation has comprehensive infection control policy and procedures which are inclusive of antimicrobial stewardship. Policies and procedures are available on the intranet and in hard copy at the nurses’ station.

While the registered nurse indicated understanding of ways to reduce infection risks, they were unaware of the term ‘antimicrobial stewardship’.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all registered nurses and care managers on standard and transmission-based precautions, provide training to all staff on COVID-19 management procedure, utilize antimicrobial stewardship tools, training to all registered nurses and care managers on policy and procedures to promote appropriate antibiotic prescribing and use.

The evidence compiled at the site audit shows the service was unable to demonstrate minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | | Non-compliant |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Non-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. | Non-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. | Non-Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Non-compliant |

## Findings

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

The Assessment Team found that the service was able to demonstrate how services and supports for daily living promote each consumers emotional, spiritual and psychological wellbeing. Consumers interviewed stated they are supported if they feel low, and a review of care planning documentation identified individualised information regarding emotional, psychological and spiritual needs of consumers.

The chaplain and leisure and lifestyle staff were observed frequently sitting and talking with a range of consumers during the site audit.

The chaplain stated she completes an initial spiritual care plan when a consumer enters the service and updates it every six months. The chaplain conducts a service on Sundays and Bible huddle on a Wednesday. The chaplain reported consumers can request spiritual services as needed and ministers are available when consumers are palliating.

The chaplain stated that she visits all consumers unless they request her not to and that she treats all consumers with dignity and respect whether they are religious or not. The chaplain also described how she supports consumers and their families during end of life care.

Consumers and representatives did not identify any concerns regarding referrals to individuals and other organisations in relation to services and supports for daily living.

Lifestyle and leisure staff stated during COVID-19 some activities had been put on hold, however these are recommencing. Staff provided examples of consumers who have been referred to physiotherapy and religious support and evidence of liaising with agencies such as the Country Women’s Association and the Men’s Shed.

A review of care planning documentation for consumers interviewed showed referrals to other organisations and the involvement of others in the provision of lifestyle services and support.

Lifestyle staff and management were able to describe how the service works in conjunction with external individuals and organisations to supplement the services and supports for daily living offered to consumers.

Staff ask consumers daily for feedback and attend food focus groups which families are invited to. Staff said they also check if any food is coming back uneaten. The menu is a four weekly cycle menu and changes every three months.

**The following five specific requirements have been found the be Non-Compliant.**

### Requirement 4(3)(a) Non-compliant

*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.*

The Assessment Team found that while some consumers who can mobilise independently, gave positive feedback about being supported to join activities and maintain their independence and quality of life other consumers who require more support to mobilise advised they are bored.

The Assessment Team reviewed care planning documentation which included information about consumers’ needs, goals and preferences, however it was not always updated in a timely manner and one care plan included disrespectful language that did not follow person centred care principles.

While a review of care planning documents for consumers identified information about what and who is important to them to promote their well-being, independence and quality of life, leisure and lifestyle care plans were not always completed yearly as per service policy.

Staff were able to describe what was important to consumers, however advised that staff shortages impacted on providing support to all consumers.

The Approved Provider responded and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on person-centred care, review all lifestyle activities in consultation with consumers and representatives, review all consumer lifestyle plans to ensure they are in line with individual preferences.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 4(3)(c) Non-compliant

*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.*

The Assessment Team interviewed consumers and representatives and found overall that they were supported to do things of interest to them and were supported to participate and keep in touch with people important to them. However, some consumers stated they were bored, and their care planning documentation reflected this.

While care planning documentation included information about what consumers liked to do and who was important to them, some consumers care plans showed minimal meaningful input with leisure and lifestyle activities.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on person-centred care, review all lifestyle activities in consultation with consumers and representatives, review all consumer lifestyle plans to ensure they are in line with individual preferences.

The evidence compiled at the site audit shows the service was unable to demonstrate services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment; and have social and personal relationships; and do the things of interest to them.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 4(3)(d) Non-compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

The Assessment Team found that some information about consumers conditions, needs and preferences is communicated in relation to services and supports for daily living, however there was information contained in some consumers care plans that had not been relayed to the kitchen, resulting in consumers not getting food and/or drinks according to their dietary requirements.

The Assessment Team interviewed consumers with some feeling that their information is not being communicated within the organisation and with others where responsibility for care is shared, and staff stated they are not always kept informed of consumers conditions, needs and preferences.

The Assessment Team found documentation in care plans and progress notes to be inconsistently completed. Reviews and revisions when a consumer’s circumstances and care needs changed were not always updated resulting in incorrect information being relayed between the clinical and catering team.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; education for all staff on communication, review all consumer dietary profiles against information held by the kitchen, review the process for communicating changes to consumer status.

The evidence compiled at the site audit shows the service was unable to demonstrate information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 4(3)(f) Non-compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The service was able to demonstrate the meals provided to consumers are varied, of suitable quality and quantity and menus are designed in consideration of consumer feedback and dietary needs and preferences, however observations of the dining experience particularly in the memory support unit show the mealtime experience is not always positive or consistent and does not optimise consumers well-being and quality of life.

While care planning documentation reviewed by the Assessment Team identified dietary requirements and preferences for consumers which aligned with consumer feedback, there was information contained in the care plans that had not been relayed to the kitchen, resulting in consumers not getting nutrition and hydration according to their dietary requirements.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to;education and training to staff on effective communication**,** ensure consumersdietary requirements and preferences align with consumer information contained in the care plans, ensure that consumer dietary requirements are relayed to the kitchen.

The evidence compiled at the site audit shows the service was unable to demonstrate where meals are provided, they are varied and of suitable quality and quantity.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 4(3)(g) Non-compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

The Assessment Team found not all equipment is safe, clean and well maintained and it is stored in an area that consumers access.

Equipment such as lifters, weigh chairs, wheelchairs and comfort chairs were stored in a corridor in a row with a strip of tape on the floor demarcating where they should be stored. The comfort chairs were observed to jut out over the line as they are too large to fit in this space. Consumers were observed to access this area.

The Assessment Team observed issues with equipment that had not been placed into the maintenance book indicating gaps with the maintenance system.

Maintenance staff could not provide evidence at the time of the site audit to prove that regular planned maintenance work is being completed. Issues with maintenance staffing resulted in no maintenance completed during the period of 7 July 2022 and 18 July 2022 and observations and reports from other staff show that work prior to this date was not always completed in a satisfactory manner.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; implementing a maintenance monitoring system, education for staff on using maintenance log.

The evidence compiled at the site audit shows the service was unable to demonstrate where equipment is provided, it is safe, suitable, clean and well maintained.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| Organisation’s service environment | | Non-compliant |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Non-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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Non-compliant |

## Findings

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

### Requirement 5(3)(a) Non-compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

The Assessment Team found the service is not easy to understand and impacts on consumers independence, interaction and function. While there are areas for consumers and their guests to socialise in, direct access from the main areas of the service to sixteen rooms is impeded by building works resulting in consumers finding it difficult to navigate the environment successfully.

On arrival to the service the Assessment Team observed the outdoor furniture beside the entrance of the service was unclean. There was no receptionist on duty and the hatch doors into the receptionist’s office were shut. While the main door into the building was automatic, the subsequent doors into the hostel area were manual and the door threshold was raised. On three different occasions during the site audit a consumer in a self-propelling wheelchair was observed having difficulty navigating the threshold of the doors independently.

The Assessment Team observed the layout and numbering of rooms is confusing. The map provided to the Assessment Team in the visitor’s folder is not up to date and rooms are numbered incorrectly. Handrails were observed in some areas of the service but often these were blocked with laundry trolleys making it more difficult for consumers to use the rails as navigational aids.

Management advised the correct route currently for staff and consumers to access the remainder of the rooms in the service is through the secure unit, with two separate locked doors and keypads. This does not optimise consumers independence and function as they have to wait for a member of staff to assist them through the secure unit. The codes for locked doors was not posted beside the doors.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; review all numbering in the facility and implement an easier to follow numbering scheme, review and improve consumer egress through main entrance, all outdoor areas to be tidied and outdoor furniture cleaned.

The evidence compiled at the site audit shows the service was unable to demonstrate the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 5(3)(b) Non-compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

The Assessment Team observed not all areas of the service environment were safe, clean or well maintained. Not all consumers are able to move freely inside the service due to ongoing renovations to the building. Maintenance issues are not consistently being reported and due to maintenance staffing issues, have not been actioned in a timely or satisfactory manner.

Staff toilets were unclean with doors left open when not in use, and accessible to visitors and consumers. The store room beside the male staff toilet was left open with cleaning equipment and cords not tied up. This was reported to management who advised this door would be kept shut, however it was observed at different times during the site audit to be open.

Most consumers said they were happy with cleaning at the service, however observations showed the environment was not always clean and renovations were impacting on some consumers access.

The maintenance supervisor said reactive maintenance is completed daily and the maintenance officer fills out a daily maintenance sheet, however he could only provide maintenance sheets for the past month as he could not find further documentation at the time of the accreditation audit.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; all outdoor areas to be tidied and outdoor furniture cleaned, implement an interim maintenance supervisory structure and oversight of day to day maintenance including management of preventative maintenance program, review the cleaning schedule and audit program.

The evidence compiled at the site audit shows the service was unable to demonstrate that the service environment is safe, clean, well maintained and comfortable and enables consumers to move freely, both indoors and outdoors.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 5(3)(c) Non-compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

The Assessment Team found not all furniture, fitting and equipment was safe, clean and well maintained. Furniture in outdoor areas was observed to be unclean and old. Some wheelchairs and mobility aids were observed to be dirty.

The maintenance supervisor provided a planned maintenance schedule that includes cleaning and review of consumer equipment by the on-site maintenance officer. He was not able to provide documentation during the accreditation audit that this had been completed as scheduled.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; implement an interim maintenance supervisory structure and oversight of day to day maintenance including management of preventative maintenance program, review the cleaning schedule and audit program.

The evidence compiled at the site audit shows the service was unable to demonstrate that furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

**Standard 6**

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | | Non-compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Non-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. | Non-compliant |

## Findings

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

The organisation has a policy that outlines the client feedback complaint process. The policy states what their commitment to client feedback is by encouraging both external and internal feedback, it states the management process including all feedback must be acknowledged, recorded, and assessed. However, the policy does not demonstrate how staff are directed to assist consumers to make a complaint. The policy refers to other policy documents and related legislation.

The Assessment Team interviewed consumers who were unable to confirm if appropriate action is taken in response to complaints as consumers were not aware of the process to make a complaint.

Consumers interviewed had not raised complaints to be able to provide feedback on the process. The consumer meetings have not been held regularly to provide open discussion on feedback and complaints.

**The following two requirements were found to be non-compliant.**

### Requirement 6(3)(b) Non-compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

The Assessment Team interviewed consumers, representatives and non-management staff who were not aware of any external methods to assist with complaints or feedback or how they escalate issues or concerns outside of the service. Consumers and representatives stated for further assistance they would speak with a member of staff, however when interviewing staff about the process they were unable to explain the process for these services or where they would go after consulting management if they were unhappy with the outcome for consumers.

The Assessment Team did observe pamphlets in the reception area and television room with details about how to access external services for interpreters, advocacy groups and raising complaints externally through the Aged Care Quality and Safety Commission.

Staff interviewed did not have knowledge of the services that are available to consumers to assist in raising and resolving complaints. Management could describe the processes; however, most staff were not aware of the services and how consumers could access further assistance to resolve any issues.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; support consumers to utilise the complaints mechanism and the use of the external complaints and advocacy system, provide training to all registered nurses and care managers on the complaints handling policy and procedure, provide training to staff on how to access advocates, language services and other methods for raising and resolving complaints.

The evidence compiled at the site audit shows the service was unable to demonstrate that Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team found that the service does not demonstrate that feedback and complaints are reviewed to improve the quality of care and services to the consumer. The Assessment Team found not all complaints and feedback are recorded and reviewed to inform the way the service is improving the quality of care to consumers.

Where complaints are recorded they are not always closed with an action summary including what steps have been taken to improve the care and services. Feedback and complaints data provides little information on how the service has resolved the feedback from the consumer.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; provide training to all registered nurses and care managers on the complaints handling policy and procedure, provide training and education for all registered nurses and care managers on the continuous improvement policy and procedure and how feedback and complaints inform continuous improvement, develop a feedback register and complete the register in detail.

The evidence compiled at the site audit shows the service was unable to demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

**Standard 7**

|  |  |  |
| --- | --- | --- |
| Human resources | | Non-compliant |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

## Findings

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

The Assessment Team interviewed consumers and representatives who confirmed that staff are kind, caring and respectful of each consumer and try their best but were constantly busy. Observations of staff interactions with consumers were to be kind, caring and respectful.

There were anonymous complaints noted regarding staff mannerism and behaviours that were sighted however overall evidence including observations indicated that staff were kind, caring and respectful towards the consumers.

**The following four requirements have been found to be Non-compliant.**

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team found that the service was able to demonstrate workforce planning, however that the number and mix of staff members to enable the delivery and management of safe and quality care and services did not always occur. The number and mix of staff working was consistent with the roster however there have been regular unfilled shifts due to the challenges faced by the service.

The changes in key personnel and impacts of workforce planning have resulted in a lack of clinical oversight and gaps in clinical care management over the period. The process in place for filling day to day vacant shifts was heavily reliant on agency staff however it was noted that the service did actively attempt to fill all shifts with consumers care being prioritised.

Most consumers and representatives stated that staffing levels was an area of concern however that staff did try their best. Staff felt that they had time to manage most required tasks when they were fully staffed. Call bell records and consumer interviews demonstrated that call bells were not always answered in a timely manner.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; engage in a significant recruitment campaign, applying retention schemes for long term employees including a wage increase effective after 1 July 2022.

The evidence compiled at the site audit shows the service was unable to demonstrate 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.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 7(3)(c) Non-compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team found that the service has systems and processes in place to ensure staff have the qualifications required upon recruitment and meet the position descriptions however it was found that mandatory training was not up to date and staff performance was not regularly reviewed as per organisation requirements.

The Assessment Team interviewed management who stated that they determine staff are competent because they only employ staff with a minimum qualification of Certificate III for care service employees, and for registered staff they hire only suitably qualified registered staff with appropriate registrations.

Management stated that there is a range of mandatory and optional education and training that is required for staff members. Staff are also provided with optional training and provided with opportunities for additional training should they wish.

Mandatory training matrixes indicated that a large number of staff had not completed their mandatory training or were out of date. Documentation on performance appraisals showed that majority of staff had overdue performance appraisals.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; schedule training for staff to complete all outstanding competencies, including manual handling, hand washing, donning and offing PPE, conduct performance reviews as scheduled.

The evidence compiled at the site audit shows the service was unable to demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team found that the service has systems and processes in place to monitor staff training and competency at an organisational and service level however it was found that most staff have not completed their mandatory training and have not kept up to date with the requirements of the organisation.

The Assessment Team interviewed consumers and representatives who overall provided positive feedback about staff, however some feedback received indicated that staff needed more training.

The service has systems and process in place to track training and education requirements to deliver outcomes required by these Standards however the service’s training records indicated that this was not occurring, and all staff had not received mandatory training in the required timeframes.

Deficiencies in Standards 2 and Standard 3 indicate that while most staff have had training it has not been effective in providing safe quality care and services. The Assessment Team observed staff completing tasks with consumers utilising unsafe manual handling procedures and reported it to management.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; schedule training for staff to complete all outstanding competencies, including manual handling, hand washing, donning and offing PPE, have the current education calendar displayed in the staff room, ensure all staff have completed the mandatory learning modules.

The evidence compiled at the site audit shows the service was unable to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 7(3)(e) Non-compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The Assessment Team spoke with management who explained the process of performance assessments, however reported numerous factors that have affected the performance assessment process including recent change in management.

The area manager stated that performance of staff is monitored and reviewed in many ways including reviewing observations, competencies, staff reviews and staff meetings. Consumer feedback is incorporated, and this is from the complaints system, compliments board and staff are provided with awards to acknowledge their work.

Staff interviewed stated that it has been a while since they last had a performance review with their management and a review of the performance appraisal schedule shows that there are twenty-one staff who have been employed for more than twelve months and twenty have overdue annual reviews.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; conduct performance reviews as scheduled.

The evidence compiled at the site audit shows the service was unable to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

**Standard 8**

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

## Findings

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

### Requirement 8(3)(a) Non-compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

The Assessment Team found that the service has a range of means and methods for consumers to engage in the development, delivery and evaluation of the care and services however it was not evident that consumers and representatives were supported in that engagement.

The Assessment Team identified gaps in all standards, which demonstrates that not all consumers are not supported to be engaged in the development, delivery and evaluation of care and services and to partner in their care.

A review of care planning documentation showed that assessments are not always being completed in line with the organisations’ policies, contained outdated information and confirmed minimal engagement of meaningful activities for some consumers within the service.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; develop a feedback register to capture complaints, compliments and suggestions, commence monthly resident and representative meetings and distribute the minutes, ensure all consumers have participated in a case conference.

The evidence compiled at the site audit shows the service was unable to demonstrate consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 8(3)(b) Non-compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

The Assessment Team found that the organisation’s governing body aims to promote a culture of safe, inclusive and quality care however that there was a lack of accountability in the delivery of care which is evidenced by the gaps identified in all standards.

In addition, the service has not been appropriately resourced to facilitate the provision of quality care and services that meet the requirements of the Quality Standards. Management stated the organisation has been challenged in recruiting and retaining staff including key personnel at the service as a result of its location and industry staffing challenges.

Gaps identified in Standard 2 and Standard 3 identify gaps in the organisations systems to monitor safe and effective clinical care. Gaps identified in other areas indicate that the systems and processes in place were not effective in ensuring safe, inclusive and quality care and services were provided.

Whilst the governing body aims to promote a culture of safe, inclusive and quality care and services the Assessment Team found the delivery is not effective. The governing body does not understand the extent of issues at the service. While some positive actions have been taken there are many identified risks across all standards.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; implement the organisation’s key process map and checklist within the internal corporate quality assurance program, complemented by improvement activity reconciliation by clinical advisor, provide training and education for all staff on how to navigate the organisation’s intranet to locate policies and procedures, provide education to all staff on antimicrobial stewardship, restraint and open disclosure.

The evidence compiled at the site audit shows the service was unable to demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 8(3)(c) Non-compliant

*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.*

The Assessment Team found that the service’s information management systems did not provide staff with readily available information they need. The organisation has detailed policies and procedures that guide staff however it was evident that most staff did not know how to access it especially agency staff that were working at the service.

Care planning documentation confirmed that assessments are not always being completed in line with the organisation’s policies and that some consumers were minimally engaged in activities within the service. Gaps in clinical documentation were identified including monitoring charts not being completed.

Review of kitchen documentation showed key consumer information including current dietary requirements, was not shared between clinical and catering teams resulting in consumers not getting the recommended meals or drinks.

The service was able to provide a plan for continuous improvement which highlights improvement idea, date of idea, area, source of idea, role responsible, date to be completed, progress report, outcomes and evaluation and completion date and the aged care quality standards and requirements it is linked to.

The plan for continuous improvement shows a methodical approach to ongoing monitoring, review and service improvement however it was noted that not all information was accurately captured to drive continuous improvement. The Assessment Team found that the organisation had a range of tools to monitor data however that there were gaps identified in all standards indicating that data and information flowing up to the governing body is not being used to drive continuous improvement at the service level.

Service management gave examples of when changes to budget or expenditure were made to support needs of consumers, and it was evident that the service changed its budget and expenditure to support the changing needs of consumers.

The Assessment Team identified gaps in Standard 6 and Standard 7, demonstrating that the service does not have effective systems in place to support workforce governance and for feedback and complaints.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; implement the organisation’s key process map and checklist within the internal corporate quality assurance program, complemented by improvement activity reconciliation by clinical advisor, provide training to all staff on complaints handling policy and procedure, ensure all staff complete mandatory training requirements, provide training to all staff on continuous improvement policy and procedure.

The evidence compiled at the site audit shows the service was unable to demonstrate effective organisation wide governance systems relating to the following: information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 8(3)(d) Non-compliant

*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.*

The organisation has risk management frameworks in place however it was found that the service’s incident management system was not effective in identifying risks to consumers care, ways to mitigate risks and drive continuous improvement.

The organisations executives stated that they can track data in real time and implement strategies on an organisational level and at a service level however evidence including documentation, observations and interviews did not support how the data tracking resulted in improvements of practice.

The Assessment Team found not all incidents involving consumers resulted in the completion of incident reports and that clinical indicator data in relation to incidents may not be accurate.

The service has a consumer high acuity risk management flowchart which is based upon high acuity risk score. The information demonstrates that there are risk management systems in place however it was not clear whether this was followed.

The Assessment Team identified instances were incidents occurred and were not identified and reported to the Serious Incident Reporting System.

The Assessment Team had to discuss specific scenarios with the service management, and post discussion the management team decided that the incident needed to be classified and reported to the Serious Incident Reporting System.

The organisation provided a documented risk management framework, including policies related to how high impact or high prevalence risks associated with the care of consumers is managed, the abuse and neglect of consumers are identified and responded to, how consumers are supported to live the best life they can, and how incidents are managed and prevented.

Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Overall mixed feedback was received, and staff were unable to provide examples of their relevance to their work.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes.

The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; provide education and training for all staff on partnership care planning, implement incident management policy and procedure training to all staff, managing incident process, referral pathways, and evaluation of actions.

The evidence compiled at the site audit shows the service was unable to demonstrate effective risk management systems and practices, including but not limited to the following: managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

### Requirement 8(3)(e) Non-compliant

*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.*

The organisation provided a documented clinical governance framework, a policy relating to antimicrobial stewardship, a policy relating to minimising the use of restraint and an open disclosure policy.

Although the organisation has a clinical governance framework in place, gaps identified in requirements of Standard 2 and Standard 3 demonstrate that the clinical governance framework has not been effective in ensuring clinical care is safe and effective.

Staff were asked whether policies had been discussed with them and what they meant for them in a practical way. There was mixed feedback about staff education regarding policies and staff were not able to provide examples of their relevance to their work.

The Assessment Team found that many staff were not aware how to access the policies and procedures on the organisations intranet. Some staff knew where to find the policy folder in the nursing station which contained documents from 2021. One care staff member interviewed who has been at the organisation for over a year stated they had never accessed or read any of the policies and procedures.

The Approved Provider responded to the Assessment Team’s report and did not refute the Assessment Team’s findings. The Approved Provider acknowledged the gaps within their systems and processes. The Approved Provider outlined their action plan to address deficiencies raised, including but not limited to; provide training and education for all staff on how to navigate the organisation’s intranet to locate policies and procedures, provide education to all staff on antimicrobial stewardship, restraint and open disclosure.

The evidence compiled at the site audit shows the service was unable to demonstrate where clinical care is provided—a clinical governance framework, including but not limited to antimicrobial stewardship; minimising the use of restraint; open disclosure.

In making my decision, I have considered the information provided by the Assessment Team and the Approved Provider. The actions planned by the Approved Provider to address the concerns raised by the Assessment Team require time to be implemented effectively and demonstrate effectiveness.

Therefore, I find this Requirement is Non-compliant.

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