Performance

Report

**1800 951 822**

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| Name of service: | NewDirection Care at Bellmere |
| Service address: | 41 Lotus Avenue BELLMERE QLD 4510 |
| Commission ID: | 5804 |
| Approved provider: | NewDirection Bellmere Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 November 2022 to 9 November 2022 |
| Performance report date: | 15 December 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 NewDirection Care at Bellmere (**the service**) has been prepared by T Wurf, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received on 7 December 2022
* other information and intelligence held by the Commission.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **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 3(3)(a)
  + Ensure personal and clinical care is safe and effective, including in relation to the behaviour management
  + Review the service’s understanding of environmental restraint to ensure practices align with the Quality of Care Principles definition and requirements for the use of a restrictive practice.
  + Implement and maintain processes to assess, determine and document the effect and the purpose of an intervention on each individual consumer, to understand whether the practice or intervention (secure perimeter, secure houses) is or is not a restrictive practice (environmental restraint). This must be done on a case-by-case basis as it depends on the consumer and their individual circumstances.
* Requirement 3(3)(b)
  + Ensure high impact and high prevalence risks associated with the care of consumers are effectively managed, including in relation to changed behaviours and smoking-related incidents.
  + Demonstrate strategies that are not successful in mitigating risks are reviewed and other strategies are trialled and that this occurs ongoing until the risk is mitigated to the greatest extent possible.
* Requirement 5(3)(b) – Ensure the service environment is clean and to the general satisfaction of consumers and their representatives.
* Requirement 6(3)(d) – Ensure feedback and complaints are reviewed and used to improve the quality of care and services.
* Requirement 7(3)(a) – Ensure there are sufficient numbers of staff to deliver safe and quality care and services.
* Requirement 7(3)(d) – Ensure staff understand and apply the knowledge gained through training and establish a system for identifying where staff do not understand training content and take corrective actions.
* Requirement 8(3)(b) - Ensure the organisation’s governance frameworks support the governing body to enable it to address deficit areas, such as risks to the health and safety of consumers.
* Requirement 8(3)(c) – Ensure an effective organisation-wide governance system relating to workforce and feedback and complaints.
* Requirement 8(3)(d) - Implement effective risk management systems and practices to effectively manage high-impact risks including but not limited to behaviour management and smoking-related incidents.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The Performance Report dated 15 December 2021 found the service non-compliant with requirements 2(3)(a) and 2(3)(e). The Performance Report included information that planning and assessment of behaviour management were not safe and effective for all consumers, and the effectiveness and outcome of reviews of care and services were not evidence.

Based on the findings contained in the Assessment Contact Report, I am satisfied the service has taken improvement actions to address non-compliance with requirements 2(3)(a) and 2(3)(e) outlined in the Performance Report dated 15 December 2021. It is my decision these requirements are now compliant. Actions included:

* Engaged a Care Manager who conducts daily reviews of consumer incidents and reviews all consumers’ care documentation in relation to risk.
* Established monthly multidisciplinary team meetings which review consumer incidents and deterioration.
* An occupational therapist conducts assessments, develops individualised plans for consumers identified as high risk of falls or changing behaviours, and provides staff coaching in the management of risks to consumers.
* Introduced an electronic care management system which staff have constant access to via handheld phones.
* A schedule for care plan reviews.

Consumers were satisfied with the service’s assessment and care planning processes. Care documentation identified key risks such as falls, pressure injury development, weight loss and swallowing difficulties. Risks associated with diagnoses, decline or past health history were assessed using validated risk assessment tools and care planning documents recorded strategies used to mitigate risks.

The service has systems and processes to review consumer care and services every six months and when a change in consumers’ health and/or wellbeing occurs. Consumers’ care documentation evidenced that reviews of care and services occur.

The organisation has policies and procedures to guide staff in assessment and care planning.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |

Findings

The Performance Report dated 15 December 2021 found the service non-compliant with requirements 3(3)(a), 3(3)(b) and 3(3)(d). The Performance Report included information that care was not always delivered or timely and risks were not effectively managed, specifically in relation to behaviour management and pressure injury management. Also, deterioration or change in a consumer’s condition was not consistently recognised and responded to in a timely manner.

*Requirement 3(3)(a)*

The Assessment Contact Report found that clinical care delivery was not safe and effective in relation to behaviour management and restrictive practice. Some consumers expressed fear related to the physically and verbally aggressive behaviours of a named consumer and described how this impacted them. Review of documentation identified for the period October 2022 to November 2022, 47 reported incidents of verbal and/or physical aggression exhibited by the named consumer. Whilst the consumer had a documented behaviour support plan, the last review was dated 19 October 2022, and staff could not provide examples of strategies implemented when the named consumer exhibited changed behaviours. Staff also reported the consumer had developed new behaviours. The consumer was referred to an external dementia specialist on 7 November 2022.

For a second named consumer, a review of documentation identified 16 reported incidents of verbal and/or physical behaviours for the period October 2022 to November 2022, including one occasion in which three staff were required to assist the consumer with care delivery due to aggressive behaviours. A referral was made to an external dementia specialist on 21 October 2022. While a documented behaviour support plan was evidenced for the consumer, it did not include notation or recommendations made by the external specialist.

For a third named consumer, the documentation review identified an increase in verbal and/or physical behaviours, with 12 reported incidents in October 2022 and one occasion on 3 November 2022, where the named consumer hit another consumer. A referral was made to an external dementia specialist on 23 March 2022, and a behaviour support plan was last reviewed on 19 October 2022. However, staff could not provide examples of strategies to support this consumer when presented with changed behaviours.

The approved provider’s response refuted the findings in the Assessment Contact Report under this requirement. The response included copies of policies, procedures, forms, templates, organisational clinical frameworks and care plan review schedules to outline how the service provides care planning tailored to each consumer's individualised needs. I am not persuaded by the approved provider's assertion, as these documents did not detail individual consumers' care.

Concerning the first named consumer, the approved provider in its response, stated strategies utilised by staff that had in the past been effective in minimising the incidents of physical and verbal aggressive episodes for the consumer were not effective due to the additional contributing factors. Information provided included:

* A copy of a root cause analysis report dated 5 December 2022. The approved provider asserted that this demonstrated clearly that staff followed documented interventions for the named consumer when presenting with changed behaviours. This argument does not persuade me as the root cause analysis was dated after the Assessment Contact and did not descend into the detail of individualised strategies to manage the consumer’s changed behaviours.
* A copy of the consumer's emotional support care plan, which identifies triggers and strategies to be implemented for the consumer's changed behaviours. The emotional support care plan dated 11 November 2022, after the Assessment Contact. It is unclear whether these strategies were in place at the time of the Assessment Contact, as previous versions of the care plan were not provided. Regardless, I have given weight to staff interviews at the time of the Assessment Contact, staff could not describe these strategies, and staff identified that the consumer had recently developed new behaviours that were not reflected in the provided emotional support care plan.
* The approved providers' response included a copy of recommendations provided by the external dementia specialist, dated 21 November 2022, after the assessment contact. No evidence of updated care plans for the named consumer was provided. Regardless, the recommendations report does not evidence adequate management of the consumers' changed behaviours.

Concerning the second and third named consumers, the approved provider's response did not provide any additional information to evidence how the service supported and managed the changed behaviours of these consumers.

The approved providers' submission responded to the named consumer who expressed fear related to the behaviours of the first-named consumer, including addressing two examples as evidenced in the Assessment Contact Report. I acknowledge the service's response in following up on this issue with the consumer, however, I give weight to the statement in the approved provider's response that the changes to the first-named consumer's medication did have a negative impact on the consumer's well-being which increased physical and verbal aggressive episodes.

I am of the view that the service did not adequately manage consumers’ changed behaviours and strategies in behaviour support plans were not sufficiently understood by staff and reviewed for effectiveness, including in response to increases in behavioural incidents.

I have considered information under requirement 5(3)(b) in relation to environmental restraint under this requirement. The Assessment Contact Report found consumers were unable to move freely outside the service as the service’s perimeter was securely locked or outside their houses between the hours of 7pm and 7am.

The approved provider’s response described the service’s environment including consumer ‘houses’ and onsite amenities and stated that consumers can freely move within the service environment. The response stated that under Quality of Care Principles, the exit door to the service may be perceived as a restrictive practice and identified it is strengthening the informed consent process by requesting consumers/representatives to sign an environmental restraint form. The date for completion of this is 23 December 2022.

I am of the view that the service is unable to demonstrate management of restrictive practices, specifically recognition and understanding of consumers who are subject to environmental restraint. The service did not demonstrate for each consumer that individualised assessments are used which align with the Quality of Care Principles definition of environmental restraint to determine when the intervention (secure perimeter, secure houses) is or is not a restrictive practice (environmental restraint).

I acknowledge the actions taken and planned by the approved provider in response to the Assessment Contact Report. This requirement requires that each consumer gets safe and effective personal care and/or clinical care that is best practice tailored to their needs and optimises their health and well-being. The service has not demonstrated effective management of behaviours in relation to the named consumers above or environmental restraint. Therefore, it is my decision requirement 3(3)(a) is non-compliant.

*Requirement 3(3)(b)*

The Assessment Contact Report found the service had failed to effectively identify and/or manage risks to consumers in relation to changed behaviours and smoking. Staff could not consistently describe risks to consumers or individualised strategies to ensure risks are minimised for consumers.

I have considered information detailed under requirement 3(3)(a) in relation to multiple consumers that experienced increased behavioural incidents of high risk behaviour (including verbal and physical aggression).

I have also considered information about smoking detailed in requirement 5(3)(b) under this requirement. The service has a designated smoking area equipped with signage, fire blanket and ashtray. Consumers who smoke had a smoking agreement and risk assessments completed.

The service’s incident data for August and September 2022 identified an increase in smoking incidents with several consumers found smoking in their rooms. Strategies to mitigate risks were documented.

A consumer told the Assessment Team they did not use the designated smoking area as it is too far away. Care documentation identified the consumer was found on several occasions not smoking within the designated smoking area of the service. Staff said they do not monitor/supervise the consumer when they smoke.

Another consumer who smokes had a number of smoking incidents, including being found asleep in bed with a lit cigarette. While staff removed the lighter and cigarettes, they were found smoking again in their room at a later date.

Management was aware of consumers’ non-compliance with smoking agreements.

The approved provider’s response included evidence of smoking agreements and risk assessments completed for consumers who smoke, plus evidence of consultation with representations where consumers were not adhering to the smoking agreement. The response stated the service takes a range of precautions to prevent smoking-related incidents, however, consumers continue to smoke in non-designated areas. The service is considering a flame-free lighter device for the smoking area which will allow the removal of individual lighters.

I am satisfied the service has a safe and dedicated smoking area and completes risk assessments and smoking agreements for those consumers who choose to smoke. Whilst I acknowledge the service has identified prevention strategies, smoking-related incidents continue to occur that present a high risk to the safety of consumers.

Therefore, it is my decision requirement 3(3)(b) is non-compliant based on the service’s failure to effectively manage high impact and high prevalence risks associated with ongoing smoking incidents and increasing incidents of consumer physical and verbal aggression and to do so in a timely manner.

*Requirement 3(3)(d)*

The Assessment Contact Report identified the service did not effectively respond to consumers whose condition had changed and named one consumer who experienced an increase in verbal/physical behaviours in October and November that had not been escalated for review by a medical officer or other external specialists, and another consumer whose documentation did not include outcomes from a recent review by a specialised dementia service. I have considered the information in relation to these two named consumers under requirement 3(3)(a).

The approved provider’s response to the Assessment Contact Report asserted the service has organisational policies and procedures relevant to this requirement, a tool to identify consumer deterioration, and clinical governance meetings that review incidents and changes/deterioration in consumers’ conditions.

The approved provider’s response has convinced me the service utilises processes to identify and respond to changes or deterioration in a consumer’s condition. Therefore, it is my decision requirement 3(3)(d) is compliant.

# Standard 5

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| Organisation’s service environment | |  |
| 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 |

Findings

The Assessment Contact Report identified the service environment was not safe or clean, and restricted consumers’ free movement. I have considered information about the cleanliness of the service environment under this requirement. I have considered other information brought forward by the Assessment Team under this requirement, and the approved provider’s response to those matters, under different requirements as follows:

* consumers feeling unsafe due to the behaviours of other consumers is considered under requirement 3(3)(a)
* the environment restricting consumers’ free movement is considered under requirement 3(3)(a), and
* smoking-related incidents under requirement 3(3)(b).

Consumers and representatives were generally dissatisfied with the cleanliness of the service. They reported that weekly cleaning by staff was not occurring and described unclean linen, bathrooms and verandas, and unclean and stained carpets. This feedback was consistent with the Assessment Team’s observations of stained carpets and dirty bathrooms. Several representatives said they had raised complaints about cleaning directly with the service.

Staff advised they did not have sufficient time to complete cleaning tasks. The service’s cleaning records for 1 to 9 November 2022 showed daily and weekly cleaning tasks had not been consistently completed.

Management said that in response to an increase trend in complaints about cleanliness, the service engaged an external cleaning contractor to complete professional cleaning jobs (including carpet steam cleaning) and additional cleaning. The service was also developing new cleaning schedules and staff training.

The approved provider’s response to the Assessment Contact Report acknowledged that cleaning was not routinely completed due to the service’s staffing environment and staff prioritising care and other tasks. The response provided broad commentary about workforce challenges affecting the residential aged care industry, staff sick leave affecting the service’s workforce, and the service’s recruitment and retention strategies to address workforce shortages. While these external factors are not disputed, the approved provider remains accountable for delivering safe, quality care and services and ensuring that it complies with the Aged Care Quality Standards.

The response identified remedial actions to address concerns about cleaning, including:

* completing additional cleaning by internal staff and external contractors, including for those consumers who had raised concerns
* expanding the cleaner’s role to cover 7 days a week and include consumer’s living environments
* increasing staff training on cleaning and communicating with staff about their responsibilities to clean and raise issues
* development of a cleaning equipment guide and cleaning chemicals guide for staff, and
* general recruitment of additional staff.

While I acknowledge the remedial actions identified by the approved provider, it will take some time to fully implement and evaluate the effectiveness and sustainability of these actions. Therefore, it is my decision that requirement 5(3)(b) is non-compliant.

# Standard 6

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| Feedback and complaints | |  |
| 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 Performance Report dated 15 December 2021 found the service non-compliant with requirements 6(3)(c) and 6(3)(d). The Performance Report included information that consumers were dissatisfied with the way the service responded to their concerns, and feedback and complaints did not improve the quality of care and services.

*Requirement 6(3)(c)*

The Assessment Contact Report identified consumers and representatives were satisfied that their complaints were resolved in a timely manner. They described management meeting with them to discuss their concerns and said strategies to resolve their concerns were implemented promptly. The service maintained documentation that demonstrated complaints were documented and resolved in a timely manner, and an open disclosure process was practised where appropriate.

The service has strengthened its complaints handling and resolution process to ensure complaints are responded to and resolved in a timely manner. Management meets with consumers and representatives to address any complaints received in a timely manner.

Based on the findings contained in the Assessment Contact Report, I am satisfied the service has taken improvement actions to address non-compliance and it is my decision that requirement 6(3)(c) is now compliant.

*Requirement 6(3)(d)*

The Assessment Contact Report identified the service did not use feedback and complaints to improve the quality of care and services and actions to address complaints have either not been fully implemented or have been ineffective in addressing trends in complaints.

Two consumers who had raised concerns about the availability of food over weekends, staff and cleaning reported that despite some resolution actions being taken, issues continue to occur. Most consumers/representatives raised cleaning as an ongoing issue, staff said they did not have enough time to complete cleaning duties as part of their role and management identified a trend in complaints about cleanliness. Actions implemented in response to consumer/representative complaints, such as engaging an external contractor to complete additional cleaning, have not been successful in improving services.

Additionally, the Performance Report dated 15 December 2021 found improvement actions to address consumer complaints about staffing numbers and risks associated with consumer behaviours did not improve care. I have considered information in the entirety of the Assessment Contact Report and noted feedback from consumers, representatives and staff that these remain areas of concern.

The approved provider’s response refuted the findings in the Assessment Contact Report and asserted that the service has a robust feedback management system and processes that initiate improvements to quality care and services. It provided commentary about the service’s actions to respond and address the concerns raised by the two named consumers. Additionally, the response clarified the dates and timelines of some concerns noted in the Assessment Teams Report, which I accept and have not considered that information further.

Whilst I acknowledge some individual consumer complaints have now been resolved, I have given weight to the feedback at the time of the Assessment Contact from consumers and representatives who had made complaints and who were not satisfied the service’s actions improved the care and services. Interventions to address concerns about cleaning have not resulted in improved services as the cleanliness of the service environment remains an ongoing issue. Therefore, it is my decision that 6(3)(d) is non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |

Findings

The Performance Report dated 15 December 2021 found the service non-compliant with requirements 7(3)(a) and 7(3)(d). The Performance Report included information that consumers were dissatisfied with staffing levels which impacted negatively on the delivery of safe and quality care and staff were not adequately trained, for example, in areas such as behaviour management.

*Requirement 7(3)(a)*

The Assessment Contact Report identified that the service has a mix of registered, care and other staff, conducts ongoing recruitment processes, and has strategies to replace staff on leave. However, most staff and approximately half of the consumers and representatives interviewed by the Assessment Team reported that staff do not have enough time to complete their scheduled tasks and identified that this negatively impacts on cleaning and timeliness of personal care.

Service documentation identified cleaning had been a consistent trend in complaints between August and October 2022. The Assessment Team observed food on floors and stained carpets. External cleaners have been engaged to reduce the cleaning requirements for staff.

The approved provider’s response refuted the findings in the Assessment Contact Report and referenced national workforce shortages affecting the residential aged care industry. While national workforce matters are not being disputed, the approved provider remains accountable for delivering safe, quality care and services and ensuring that it complies with the Aged Care Quality Standards.

The response gave general information about “total care hours” delivered by staff, how the service plans and manages workforce allocation, and various roles in the organisation that can be utilised to backfill unplanned leave and provide assistance with personal care, preparing meals and cleaning. I acknowledge an external cleaning contract was engaged to provide additional cleaning and the service’s ongoing recruitment and retention processes.

I have given weight to the significant consumer, representative and staff feedback that staff have insufficient time to complete their tasks, including cleaning and delivering personal care in a timely manner. On this basis, I am of the view the service has an insufficient number of staff to ensure delivery and management of timely care and cleaning services. Therefore, it is my decision that requirement 7(3)(a) is non-compliant.

*Requirement 7(3)(d)*

The Assessment Contact Report identified that whilst most consumers and representatives were confident staff know what they are doing, some representatives felt staff required more training in various areas such as hygiene care, nutrition (weekend staff) and feeding.

Whilst staff said they receive a range of training and support on various topics, they failed to demonstrate appropriate knowledge of these topics when interviewed by the Assessment Team, including in relation to the Quality Standards and restrictive practices.

Service documentation demonstrated new staff receive induction, orientation and support, and mandatory training has very high staff completion levels. Management identified high staff turnover and processes to deliver training, however, noted the effectiveness of training had not been evaluated.

The approved provider’s response disagreed with the findings in the Assessment Contact Report and stated the service has recruitment processes to recruit and retain qualified and suitable staff and a staff induction and training program. I accept this.

The response also acknowledged staff may require ongoing training and referred to various new positions, including a Quality and Education Coordinator and Clinical Team Leaders, that provide additional staff education and training where required and provide weekend coverage at the service to monitor and support staff. Additionally, the service has arranged extra staff training on the Quality Standards and restrictive practices scheduled for December 2022.

I am of the view that whilst staff receive training, this has not been effective in ensuring staff understood and applied that training in their practice to meet the outcomes required by these Quality Standards. Therefore, it is my decision requirement 7(3)(d) is non-compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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 |

Findings

The Performance Report dated 15 December 2021 found the service non-compliant with requirements 8(3)(b), 8(3)(c) and 8(3)(d). The Performance Report included information about the governing body not being accountable for ensuring risks to consumers were effectively managed, continuous improvement and workplace governance system not being effective, and risk management systems and practices were ineffective in the management of high impact risks.

*Requirement 8(3)(b)*

The Assessment Contact Report found whilst the governing body promotes a culture of safe, inclusive and quality care, it has not been accountable for ensuring appropriate action is taken in response to risks to the health and safety of consumers. For example:

* Review of the service’s serious incident response scheme (SIRS) register indicates 23 incidents involving aggressive behaviours of consumers towards other consumers in the 4 months from July 2022 to October 2022.
* The service’s Plan for Continuous Improvement (PCI) identifies a need to improve risk and hazard management and incident management documentation. However, the PCI does not identify actions or strategies to be taken to prevent incidents of aggressive behaviours.
* Some consumers/representatives reported fear due to the aggressive behaviours of other consumers.
* While management leadership meetings evidence discussion of aggressive behaviours of consumers, there is a continuing pattern of consumer aggressive behaviours resulting in reportable incidents.
* Review of consumer care documentation indicates frequent instances of consumers being physically aggressive towards staff. This issue does not appear to have been identified by management as an issue to be addressed.

The approved provider’s response refuted the claim that the governing body was unable to demonstrate accountability for the delivery of safe services, however, provided evidence of actions to improve the service’s incident management including:

* Updating the incident management policy that includes an incident management process and form.
* Root Cause Analysis to be completed for all Priority 1 SIRS incidents.
* All incidents will be reviewed and discussed at weekly clinical governance meetings.
* Various processes to communicate to relevant staff additional strategies or actions to prevent the recurrence of critical/incidents
* Education for registered and care staff in response behaviours, which includes incident management and SIRS.
* Ensuring best practice is followed by reviewing the relevant website in relation to incident management and SIRS reporting criteria.

I acknowledged the remedial action taken and planned to improve the governing body’s accountability in managing risks to the health and safety of consumers, however, the improvements are still in progress and not yet evaluated. For these reasons, it is my decision that requirement 8(3)(b) is non-compliant.

*Requirement 8(3)(c)*

The Assessment Contact Report identified systems relating to continuous improvement, regulatory compliance and feedback and complaints were not effective. Deficiencies related to incident management systems, with incidents not effectively managed; regulatory compliance systems, with reportable incidents not consistently identified and reported by staff; and complaints systems, with consumer/representative complaints not resulting in improved care and services.

The approved provider’s response disagreed with the Assessment Contact Report findings. The response included statements that the organisation had robust governance systems and governance meeting structures. It also clarified dates and information relevant to regulatory compliance and continuous improvement processes, which I accept. However, the response did not provide evidence or convince me robust governance systems were in place for feedback and complaints.

I have also considered information and findings of non-compliance in Standards 6 and 7. I am satisfied the service’s workforce governance systems were not effective in ensuring adequate staffing numbers and that staff understand and apply training. Further, governance systems have been ineffective in ensuring that identified complaint trends are used to improve care and services. Therefore, it is my decision requirement 8(3)(c) is non-compliant in relation to sub-requirements (iv) workforce governance and (vi) feedback and complaints.

*Requirement 8(3)(d)*

The Assessment Contact report identified the organisation’s risk management system was ineffective in managing and preventing incidents of high impact / high prevalent risks associated with the care of consumers.

The approved provider’s response refutes the findings in the Assessment Contact Report.

The service’s SIRS register recorded 23 instances of physically aggressive behaviours by consumers against other consumers between July and October 2022. Consumer care documentation also recorded high instances of aggressive behaviours toward staff. The approved provider’s response clarified the number of Priority 1 SIRS incidents.

The Assessment Contact Report referred to an incident in August 2022 that was not reported as a SIRS priority 1. The approved provider’s response clarified the incident occurred in September 2022 and provided evidence it was reported appropriately. I have, however, considered the Commission’s SIRS investigation findings that referenced the matter, including that the approved provider had not demonstrated appropriate and effective responses to mitigating behaviours of concern or evidenced that the incident management system was effective in mitigating or minimising further incidents.

I have also considered information and findings in Standard 3 under this requirement.

I am of the view that the organisation’s risk management systems have not effectively managed high impact or high prevalence risks associated with the care of consumers, or managed and prevented incidents, specifically in relation to changed behaviours and smoking. Therefore, it is my decision that requirement 8(3)(d) is non-compliant.

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