Performance

Report

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| Name of service: | Para Hills Residential Care |
| Service address: | 50 Kesters Road PARA HILLS WEST SA 5096 |
| Commission ID: | 6962 |
| Approved provider: | L R Rositano & M Rositano & R M Rositano and S P Rositano |
| Activity type: | Site Audit |
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| Performance report date: | 12 January 2023 |

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 Para Hills Residential Care (**the service**) has been prepared by J Renna, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* The Assessment Team’s report for the Site Audit; 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 on 5 December 2022, indicating acceptance of the Assessment Team’s findings. The response also includes information and evidence demonstrating actions to address deficits in the Assessment Team’s report have been taken and/or planned, including, but not limited to, staff education and training, consultation with named consumers, updating the service’s Plan for continuous improvement, review of policies, procedures, systems and accountability structures, and implementing improvements to the nutritional status of meals.

# Assessment summary

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| 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 | **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.

Standard 1 Requirements (3)(a) and (3)(d)

* Ensure consumers are provided care and services in a way which ensures they are treated with dignity and respect, with their dignity, culture and diversity valued.
* Ensure staff interactions with consumers are monitored to ensure kind, caring and respectful interactions are maintained at all times.
* Ensure consumers are supported to take risks and the consequences of these risks are discussed and agreed management strategies implemented in consultation with consumers and/or representatives.
* Ensure staff have the skills and knowledge to identify, assess, monitor and review consumers who wish to take risks.
* Review processes, policies and procedures relating to supporting consumers to exercise choice and independence.

Standard 2 Requirements (3)(a) and (3)(e)

* Ensure staff have the skills and knowledge to:
  + initiate assessments and update care plans where changes to consumers’ health are identified or when incidents occur; and
  + recognise risks associated with consumers’ choices and changes to consumers’ health and well-being and initiate assessments, implement and/or review strategies and monitor effectiveness.
* Ensure consumer care plans are updated and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

Standard 3 Requirements (3)(a), (3)(b) and (3)(g)

* Ensure staff have the skills and knowledge to:
  + identify restraint and implement appropriate measures to ensure informed consent is obtained, it is used minimally and as a last resort, and it is monitored;
  + appropriately monitor indwelling catheters in line with consumers’ needs and the organisation’s process;
  + administer medications in line with best practice guidelines and Medical officer directives;
  + monitor consumers’ blood glucose levels (BGLs) in line with Medical officer directives and implement appropriate monitoring strategies where readings are outside of acceptable ranges, including notifying a Medical officer;
  + implement appropriate behaviour management strategies to minimise the impact of these behaviours on other consumers’ safety.
  + follow the organisation’s processes and best practice guidelines in relation to infection prevention and control (IPC) practices, including screening processes and use of personal protective equipment (PPE);
  + monitor infections and antibiotic usage;
  + report, document and manage clinical incidents;
  + initiate assessments, develop appropriate management strategies and monitor effectiveness of strategies relating to restraint, indwelling catheters, diabetes and behaviour management; and
  + ensure care plans are accurate and reflective of each consumer’s current care and service needs.
* Ensure policies, procedures and guidelines in relation to best practice care, management high impact or high prevalence risks and IPC practices are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care, management high impact or high prevalence risks and IPC practices.

Standard 5 Requirement (3)(b)

* Review processes in relation to safety of the smoking area.
* Review processes relating to maintenance, including management of gardens and identification of repairs that need to be undertaken.

Standard 6 Requirements (3)(a), 3(c) and 3(d)

* Ensure feedback and complaints, including those received verbally are documented on the feedback register and appropriately actioned.
* Ensure feedback and complaints data is regularly reviewed to identify trends and improvement opportunities to the quality of care and services.
* Ensure feedback is provided to consumers, representatives and others in relation to receipt of complaints and action taken in response.

Standard 7 Requirements (3)(c) and (3)(e)

* Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training to address the deficiencies identified in seven of the eight Quality Standards.
* Ensure attendance at training sessions is monitored and non-attendance managed and addressed.
* Ensure regular staff performance review processes are conducted, staff are effectively monitored, and issues identified with staff practice and competency appropriately addressed.

All Requirements in Standard 8

* Ensure consumers and representatives are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Ensure the governing body effectively monitors the timelines of implementation of actions to address deficiencies related to the non-compliance with the Quality Standards, including ensuring regular reporting from management.
* Ensure the governing body receives adequate information to ensure safe and quality care is being provided to consumers.
* Review the organisation’s governance systems in relation to information management, continuous improvement and feedback and complaints.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers, incident management and supporting consumers to live the best life they can.
* Review the organisation’s clinical governance framework in relation to non-compliance identified.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | 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. | Non-compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirement (3)(a)

The Assessment Team was not satisfied the service demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Specifically, four consumers and representatives provided examples where staff had not treated consumers with dignity and respect, and staff were not consistently observed ensuring consumers were treated in a dignified manner. The Assessment Team provided the following evidence relevant to my finding:

* Two representatives for one consumer provided two examples when staff dismissed the consumer’s requests, including requests to dress up when attending outings and having a larger meal during the evening. They said staff told the consumer they would need to change their preferences as ‘this is how aged care works’.
* One consumer said they have been incontinent on one or two occasions, as there is not enough staff available during the late afternoon to evening, which causes them to feel embarrassed.
* One consumer said they use the call bell at night when their roommate is unsettled and calling out, to alert staff of their need for assistance. The consumer said they were told by night staff to mind their own business.
* During the Site Audit, at least three consumers were observed to be dressed in outfits with food stains.
* On one occasion, one consumer was observed to be left on a toilet adjacent to the hallway with the door remaining open, whilst the attending staff member was talking to other staff in the hall.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

I have considered that consumers were observed to be wearing food-stained clothes, and one consumer was left on a toilet with the door open, which was visible to those in the hallway. I have also considered examples provided by consumers and representatives demonstrating staff had not respected consumers’ preferences, made them feel embarrassed and/or were told to mind their own business. I find these examples do not demonstrate dignity and respect towards consumers.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice.

Requirement (3)(d)

The Assessment Team found the service demonstrated each consumer is able to take risks to enable them to live the best life they can, however, they were not satisfied appropriate supports are in place to enable consumers to take these risks safely. The Assessment Team provided the following evidence relevant to my finding:

* Staff were not aware of the risk management process for dignity of choice.
* Sampled dignity of risk forms did not include a risk assessment and while some consent forms for risky activity had been signed, there was no evidence indicating discussion about associated risk and mitigation strategies had occurred with consumers and/or representatives.
* Staff and management confirmed a list of consumers who leave the service independently is not maintained, with reception staff required to memorise them. Reception staff recited only eight consumers, despite the Assessment Team noting nine leave independently.
* None of the nine consumers who leave the service independently had a dignity of risk form or risk assessment completed. Care plans for two of the nine consumers who leave independently demonstrate they need direct supervision with their mobility.
* One consumer who has a sensory impairment and Parkinson’s disease, and requires staff supervision for all mobility needs, smokes within the designated smoking area, self-administers medication and leaves independently.
  + The dignity of risk form for their smoking did not identify sensory impairment and reduced grip strength as a risk, did not include a risk assessment or risk rating, did not indicate observations had occurred to ensure the consumer could do this task safely, and did not describe any mitigation strategies. The consumer keeps their cigarettes and lighter in their room and was observed not to be wearing a smoking apron on two occasions. Staff confirmed the consumer manages use of their smoking apron independently.
  + Staff interviewed were not aware of mitigating strategies to support the consumer in leaving independently.
  + The consumer has a self-medication assessment in place; however, it does not indicate an observation and assessment was undertaken for their ability to do this task effectively.
* Representatives expressed concern for one consumer who continues to drive, despite being commenced on oral cannabis as a pain relief. The consumer did not have a dignity of risk form or risk assessment in place and management were unaware the consumer was driving.
* One consumer is prescribed a nicotine vape, which is kept in their shared room. A medication self-assessment and risk assessment has not been completed for this device and the consumer was observed using it in the hallways without staff intervening. Staff confirmed the consumer has been using the device in their room and has been asked not to use it inside. The Assessment Team noted the designated smoking area is outside the secure area of the building, however, the consumer’s care plan states they are unable to leave independently.
* One consumer is prescribed medicinal cannabis orally and via a vape device and self-administers insulin. The consumer’s medication self-assessment does not include the use of the vape device and a risk assessment had not been undertaken assessing the impact medical cannabis may have on their ability to self-administer insulin. The consumer keeps their vape device on their bedside table and smokes cannabis vape in their room. A recent complaint has been made from another consumer about the odour and an incident occurred where the vape device had been set at a higher than recommended heat level, increasing the odour. This error did not trigger an ongoing review or reassessment of the consumer’s ability to safely use the device.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate each consumer is safely supported to take risks to enable them to live the best life they can.

I have considered that risk assessments were not consistently undertaken, and mitigation strategies were not implemented, for consumers who undertake activities that include an element of risk, despite having known impairments and/or conditions that may increase the likelihood of harm occurring or following incidents. I have also considered the lack of evidence indicating discussion about associated risk and mitigation strategies had occurred with consumers and/or representatives.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

Requirements (3)(b), (3)(c), (3)(e) and (3)(f)

Consumers and representatives said consumers receive culturally safe care and services. Staff were observed to know consumers well, and staff said they strive to provide care in a way that is consistent with consumers’ cultural preferences. Management provided examples of how culturally safe care and services are provided, including respecting consumers’ faith.

Some consumers and representatives raised concerns about how decisions are communicated with them, and about being able to maintain connections with those outside the service, as visiting hours end at 3pm daily. However, overall, consumers said they are supported to make decisions about their care, and can make connections with others and maintain relationships of choice. Staff provided examples of how they support consumers to maintain relationships, including sitting them together during meals and helping them get ready to go out into the community.

Consumers said they are provided information that is accurate and understandable, which enables them to make choices about their care and services. Staff described methods used to ensure information is clear and understood by consumers, including using simple language and tailoring communication to consumers’ needs. Information is provided to consumers via various mechanisms, including activity calendars, newsletters, resident and representative meetings, and food focus groups.

Consumers confirmed their privacy is respected, including when receiving care. With the exception of one occasion when a consumer was placed on a toilet adjacent to the hallway with the door open, and another occasion when a consumer’s personal information was observed to be left in a public area for the day, staff were overall observed ensuring consumers’ privacy was maintained. Care related documents are stored in the nurses’ station and password protection is used for the electronic care system. Policies are in place to guide staff in relation to confidentiality and privacy, and these are reinforced as part of orientation processes. Staff confirmed they were aware of these policies.

Based on the information summarised above, I find the service compliant with Requirements (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice.

# Standard 2

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

Findings

Requirement (3)(a)

The Assessment Team was not satisfied the service demonstrated 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 provided the following evidence relevant to my finding:

* One consumer’s admission assessment indicates they are prescribed opioid pain relief medication and identifies a number of other medications the consumer is allergic to. The consumer’s medication chart does not indicate they are prescribed opioid pain relief medication and staff said the consumer is allergic to it. In response to feedback from the Assessment Team, the consumer’s medication assessment was amended.
* Three consumers’ assessments included conflicting information regarding the level of supervision required. All three consumers’ smoking assessments state they can exit the service unsupervised to smoke, however, their mobility assessments state they are to be supervised and assisted with all mobility.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not 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.

I have considered that documents used to inform the care delivery for one consumer incorrectly stated they are prescribed opioid pain relief medication, which staff say the consumer is allergic to. I have also considered that documents used to inform the care delivery of three consumers included conflicting information to guide staff in their supervision requirements. Therefore, I find assessment and planning processes were not effective in ensuring consumers’ safety, health and well-being are not compromised.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

Requirement (3)(e)

The Assessment Team was not satisfied the service demonstrated 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 Assessment Team provided the following evidence relevant to my finding:

* One consumer’s medication assessment was not updated following prescription of a nicotine inhalation device. An assessment was not completed in relation to the consumer’s self-administration and management of the device.
* One consumer’s behavioural interventions and strategies were not reviewed or updated following an increase in agitation and aggression. The Medical officer reviewed the consumer and prescribed an increase in psychotropic medication.
* Consumers who voiced they were in pain did not have their pain assessments reviewed to ensure strategies were effective.
* When consumer’s care needs changed due to general deterioration, assessments were not updated.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate care and services are reviewed for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

I have considered that assessment and planning processes did not ensure care and services meets consumers’ needs safely and effectively, and that care and service plans are up-to-date and meet consumers’ needs, goals and preferences. This is evidenced by the service’s failure to reassess the effectiveness of interventions for consumers who are voicing pain or demonstrating an increase in behaviours, to ensure care plans meet consumers’ needs following general deterioration, and assess one consumer’s use of a self-administered and managed nicotine inhalation device.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

Requirements (3)(b), (3)(c) and (3)(d)

There are processes to ensure assessment and planning identifies consumers’ needs, goals and preferences. Advance care and end of life planning are completed on entry and any other time as needed. When a consumer enters their end-of-life phase, palliative care assessments are completed and include interventions for pain management, medical treatment, mobility/transfer, sleep and emotional support. Staff described where they would find information regarding consumers’ end of life wishes.

Care plans were reflective of the consumer and inclusive of those involved in the care of the consumer, including relevant health specialists. Most consumers and representatives said they were involved in assessment and planning on an ongoing basis.

Outcomes of assessment and planning are communicated to consumers and representatives via various mechanisms, including phone, face-to-face and written correspondence. Most consumers and representatives said consumers’ care plans had been discussed with them and were satisfied with the communication they receive in relation to care plans.

Based on the information summarised above, I find the service compliant with Requirements (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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

Findings

Requirement (3)(a)

The Assessment Team was not satisfied the service demonstrated each consumer receives safe and effective care that is best practice, tailored to their needs, and optimises their health and well-being. The Assessment Team provided the following evidence relevant to my finding:

* Of the 33 consumers subject to environmental restraint, two had out-of-date environmental restraint forms, three did not have consent forms signed by a representative, and one included inaccurate information. Management was unclear when authorisation for environmental restraint is required and arranged a Registered nurse to address this process. Internal audits for the use of environmental restraint have not been undertaken.
* At the entry meeting, management advised one consumer was subject to chemical restraint. The consumer’s chemical restraint authority form only identified one psychotropic medication and did not include all of their regular and as required medication used for the purposes of influencing their behaviour. Management acknowledged there is some confusion about what is considered a chemical restraint. The service’s psychotropic medication list demonstrated an additional 18 consumers were prescribed psychotropic medication.
* One consumer’s indwelling catheter was not monitored daily to ensure it is effective and not blocked. The output monitoring chart for a six-day sampled period, records output on only four days. The consumer said they empty their own catheter and record the amount; however, staff do not monitor how much is being emptied per day.
* Medication charts show one consumer was administered medication that was not in line with Medical officer’s directive for use.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate each consumer receives safe and effective care that is best practice, tailored to their needs, and optimises their health and well-being.

I have considered that nine sampled consumers did not receive best practice care. In relation to the use of restraint for six consumers, informed consent was either out-of-date or had not been obtained, or consent forms were inaccurate. Additionally, one consumer’s indwelling catheter was not monitored daily as required and another consumer was administered medication outside the Medical officer’s directive for use. I find the service’s failure to provide safe and best practice care has placed these consumers at risk of harm.

To meet this Requirement, the service is expected to demonstrate how they refer to national guidelines on safe and effective care and service delivery, however, this did not occur, as management was unclear about when authorisation for restraint is required and acknowledged there is some confusion about what is considered chemical restraint.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

Requirement (3)(b)

The Assessment Team was not satisfied the service demonstrated high impact or high prevalence risks associated with the care of consumers is effectively managed. The Assessment Team provided the following evidence relevant to my finding:

* Two consumers with diabetes did not have their BGLs monitored and recorded in line with the Medical officer’s directives, and the Medical officer was not informed when their BGLs were outside of range. One of the consumers was not monitored to ensure they were self-administering the correct amount of insulin as per the medication chart. The consumer described how often their medication needs to be administered each day, however, this description was not consistent with their medication chart. For the other consumer, documentation shows their BGLs are high prior to meals, however, no medical review was sought. Additionally, their documented baseline levels were not consistent with their diabetic pathway.
* Interventions trialled have not been consistently documented for one consumer who displays a number of ongoing behaviours. The consumer is prescribed psychotropic medication for anxiety, and behavioural and psychological symptoms of dementia. Documentation shows the consumer was not monitored hourly, in line with their monitoring chart. The consumer was referred to Dementia Support Australia (DSA) on 6 September 2022, however, this referral has been stalled. The Assessment Team noted an email from DSA to the service advising they are unable to proceed with the referral, as they have been trying to contact them with no response.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate high impact or high prevalence risks associated with the care of consumers were effectively managed.

I have considered that risks associated with diabetes were not monitored or managed in line with Medical officer directives for two consumers. I have also considered that monitoring did not occur for one consumer to ensure they are self-medicating the correct amount of insulin, and Medical officer input was not sought for the other consumer who was experiencing elevated BGLs prior to meals. This Requirement expects the service to demonstrate all necessary steps have been taken to manage risks associated with the care of each consumer, however, I find this did not occur.

I have considered that psychotropic medication administered to one consumer for behavioural and psychological symptoms of dementia, falls within the definition of chemical restraint. I have also considered the lack of evidence demonstrating this medication was used as a last resort as required under the *Quality of Care Principles 2014*, as interventions were not consistently documented. Despite having ongoing behaviours, the consumer was not monitored hourly as required and their referral to DSA was not followed up, even though it had been made at least two-months prior.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

Requirement (3)(g)

The Assessment Team was not satisfied the service demonstrated appropriate application of standard and transmission-based precautions to prevent and control infection. The Assessment Team provided the following evidence relevant to my finding:

* On day one of the Site Audit, management informed the Assessment Team that a visitor who attended the service the day prior tested positive for COVID-19. No additional precautions were implemented for the consumer who was a close contact while waiting for a rapid antigen test (RAT) to be undertaken. Staff were observed entering the consumer’s room and walking straight into other consumers’ rooms within the area.
* The service only has one IPC lead and management was unable to demonstrate what happens if that person was unavailable.
* Some representatives and a Medical officer were observed not following the service’s process, which requires all visitors to undertake a RAT on entry. For visitors who did follow the process, no staff were observed checking results to ensure they were negative.
* Throughout the Site Audit, numerous staff were observed not wearing face masks or pulling them under their chin. Management said staff were no longer required to wear masks, however, due to a consumer being a close contact, masks were re-introduced.
* The service was unable to provide the numbers of staff that had undertaken, or were still required to undertake, mandatory infection control training.
* The service was unable to demonstrate how they monitor infections and antibiotic usage, and ensure pathology testing is undertaken prior to commencement of antibiotics. The service does not maintain an infection register and management confirmed they do not capture this information.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate minimisation of infection related risks through application of standard and transmission-based precautions to prevent and control infection, and practices to promote appropriate antibiotic prescribing and use.

In relation to the consumer who was a close contact, I have considered that no additional measures were implemented to prevent the spread of infection and ensure other consumers’ safety. On the contrary, staff were observed entering the consumer’s room and walking straight into other consumers’ rooms, which increases the risk that infection may spread.

I have considered that the service’s IPC processes were not consistently followed, as all visitors observed did not undertake a RAT on entry, and some staff were observed either not wearing masks or wearing them incorrectly. Where visitors were observed undertaking a RAT, results were not checked by staff to ensure it was negative.

I have also considered the service has not implemented measures to ensure other staff have appropriate knowledge and skill, in the event the IPC lead is unavailable. Furthermore, the service has not monitored staff completion of mandatory infection control training.

Finally, I have considered that antibiotic usage and infections are not monitored to ensure interventions are effective and used appropriately.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

Requirements (3)(c), (3)(d), (3)(e) and (3)(f)

There are processes in place to ensure needs, goals and preferences of consumers nearing the end of life are recognised and addressed, with their comfort maximised and dignity preserved. Staff confirmed they had received training in relation to end of life care and described what is important when providing this type of care. Documentation for one sampled consumer shows when they were nearing end of life, regular pain and comfort checks occurred, mouth and eye care was completed, and repositioning was attended. Staff responded promptly in relation to pain or discomfort, which were recorded as effective.

Documentation and interviews with staff showed deterioration in consumers’ health, cognition or physical function is recognised and responded to in a timely manner, including initiating appropriate referrals, conducting assessments and implementing additional clinical care congruent to changed needs. Two representatives and two consumers said appropriate and prompt action had been taken in response to deterioration in health, and confirmed assessments, observations and medical reviews were undertaken.

Information regarding consumers’ condition, needs and preferences is documented on a care plan and readily available to staff and others where responsibility for care is shared. Staff said they access up-to-date consumer information through care plans, updates and at handover. Consumers and representatives considered consumers’ needs and preferences are effectively communicated between staff.

Care planning documents showed timely and appropriate referral to other services and organisations for additional review and treatment of consumers’ health care needs. Consumers and representatives said referrals to other providers of services are made in a timely manner.

Based on the information summarised above, I find the service compliant with Requirements (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 3 Personal care and clinical care.

# Standard 4

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

Findings

Overall, sampled consumers considered the service supports them to do the things they want to do, and which are important for their health and well-being.

Consumers confirmed their needs, goals and preferences are considered, and the care and services they receive optimises their independence, health, well-being and quality of life. Staff described how they work with consumers and other organisations when further supports are required for consumers’ health and well-being.

Services and supports are in place to promote each consumer’s emotional, spiritual and psychological well-being. Staff confirmed they received additional training to enhance their awareness of caring for consumers’ emotional and psychological well-being. Two staff have been appointed as official ‘resident advocates’ to support the emotional and psychological well-being of consumers. The service has engaged Relationships Australia to provide counselling and emotional support to 12 consumers. One of these consumers said this has helped them considerably.

Consumers described how they are supported to participate in their community within and outside the organisation’s service environment, have social and personal relationships and do things of interest to them, including participating in lifestyle activities, leaving independently to meet friends and family, and attending religious groups. Staff demonstrated good knowledge of consumers, including their social connections.

There are processes in place to ensure information about the consumer’s condition, needs and preferences are communicated within the organisation, and with others where responsibility for care is shared. These include handover sheets, handover and staff meetings, and by accessing the electronic clinical management system. Consumers and representatives said staff were consistent, competent and understood consumers’ care needs and preferences.

Consumers and representatives confirmed consumers are referred to other individuals, organisations and providers of other care and services as needed. Examples provided included Dementia Services Australia, Relationships Australia and mental health professionals.

Most consumers interviewed gave positive feedback about the food and stated the food is of suitable quality and quantity. Meals are prepared on site and management advised a food focus group has been established to obtain consumer feedback on the menu and dining experience. Staff confirmed they check the handover sheet to identify whether a consumer has any changes in meal preferences or texture.

Equipment used to support daily living was observed to be safe, suitable, clean and well maintained. Consumers said they feel safe when using the equipment, and staff demonstrated an understanding of preventative and reactive maintenance processes to ensure equipment is clean and in good condition.

Based on the above evidence, I find the service compliant with all Requirements in Standard 4 Services and supports for daily living.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Requirement (3)(b)

The Assessment Team was not satisfied the service demonstrated the service environment is safe, clean and well-maintained. The Assessment Team provided the following evidence relevant to my finding:

* Two representatives for one consumer raised concerns that mouse faeces had been found in the consumer’s room on two occasions. The representatives said the consumer’s room is not adequately cleaned and said this has not improved following these incidents. Management said the consumer eats in their room and on both occasions, pest control had visited the service in response.
* The smoking area did not include a fire blanket or extinguisher. On the first day of the Site Audit, the ash bin was observed to be on fire. A fire blanket was placed in the area on the second day of the Site Audit; however, it had not been checked since August 2021.
* The garden in one area of the service was observed to be significantly overgrown and holes were observed in the fencing.
* The roof was observed to be cracking and falling in an outside storage area. While the area was fenced off, it was not locked, resulting in consumers having access.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate the service environment is safe, clean and well-maintained.

In relation to the consumer who had mouse faeces in their room, I have considered there is insufficient context and evidence to determine whether a deficiency has occurred. It is unclear whether additional cleaning had been implemented in response to the complaint, whether the room was observed to be unclean, or whether consultation with representatives had occurred or were ongoing.

In relation to the other evidence in the Assessment Team’s report, such as a lack of fire blanket or extinguisher in the smoking area, overgrown gardens, and damaged roof, I have considered that it demonstrates at the time of the Site Audit, the service environment was not safe, clean and well-maintained.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

Requirements (3)(a) and (3)(c)

The service environment was observed to be well signed to enable easier navigation. Rooms in each wing were clearly marked and were observed to be spacious and personalised. Consumers and representatives said consumers feel safe. Items that encourage a sense of belonging were observed throughout the service environment, including artwork created by consumers and plaques for tournaments. Consumers and visitors were observed using communal seating areas to interact.

Equipment was observed to be well maintained and adequately stored. Preventative and reactive maintenance processes are in place. Maintenance logs demonstrated most requests are actioned within 24 to 48 hours.

Based on the information summarised above, I find the service compliant with Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment.

# Standard 6

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

Findings

Requirement (3)(a)

The Assessment Team was not satisfied the service demonstrated consumers, representatives and others are encouraged and supported to provide feedback and make complaints. The Assessment Team provided the following evidence relevant to my finding:

* Five of 18 consumers, and two representatives, said they did not feel supported to provide feedback or make complaints and considered systems in place to do so were arduous and ineffective.
  + One representative said they requested a complaint form to raise concerns about their family member’s care, however, they never received it.
  + One representative said their family member expressed concerns about them raising complaints and stated ‘you’ll cause trouble for us’.
  + One consumer said they were told to ‘mind their own business’ when using their call bell to alert staff about another consumer. The consumer said they have not raised this with management, as ‘management wouldn’t listen anyway’.
* Staff said they did not feel they could raise concerns or feedback to management, as nothing was ever done in response.
* The feedback log shows only three complaints recorded in the six months prior to the Site Audit. Sampled Resident meeting minutes included the same feedback repeated for several months.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate consumers, representatives and others are encouraged and supported to provide feedback and make complaints.

I have considered the intent of the Requirement, which expects that consumers have trust and confidence there won’t be negative consequences if they raise concerns or complain, and that best practice complaint handling and resolution systems are in place that facilitate and support consumers to make complaints. I find feedback provided to the Assessment Team indicates the service does not meet this expectation and demonstrates a lack of confidence from consumers and representatives that complaints with be listened to and actioned appropriately, and that there will be no negative repercussions. I have also considered that a significant portion of consumers interviewed demonstrated dissatisfaction with the level of support they receive in making complaints or providing feedback.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 6 Feedback and complaints.

Requirement (3)(b)

Consumers are aware of, and have access to, advocates, language services and other methods for raising and resolving complaints. Leaflets in relation to external complaints services were observed placed in communal areas and were in different languages. Information relating to internal and external complaints processes are contained in the Resident handbook. The Aged Rights Advocacy Service attends the service regularly and hosts meetings with consumers and representatives.

Based on the information summarised above, I find the service compliant with Requirement (3)(b) in Standard 6 Feedback and complaints.

Requirement (3)(c)

The Assessment Team found the service was unable to demonstrate appropriate action has been taken in response to complaints and feedback. The Assessment Team provided the following evidence relevant to my finding:

* The feedback log shows only three complaints recorded in the six months prior to the Site Audit. There have been no further complaints logged since August 2022. The two complaints made in August 2022 had been marked as resolved, however, no formal outcome was recorded.
* Two representatives provided examples of multiple concerns raised, however, these have not been recorded on the feedback log. While one of the examples was documented in progress notes, there was no evidence of actions taken to resolve these concerns. Both representatives felt their concerns had not been adequately addressed or followed through, and said no conversation was had with them about actions taken.
* Evidence in the Assessment Team’s report under Requirement (3)(a) in this Standard included a comment from management that only formal complaints are recorded on the feedback register.
* Sampled Resident meeting minutes included the same feedback repeated for several months.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, appropriate action had not been taken in response to complaints and feedback.

I have considered the intent of the Requirement, which expects that best practice complaint handling and resolution systems are in place to manage and resolve complaints. Evidence in the Assessment Team’s report indicates the service does not meet this expectation, as there are no systems in place to ensure all complaints are recorded and monitored to ensure they have been actioned appropriately. Documentation and interviews with management shows that only formal complaints are recorded on the feedback log, which has resulted in unresolved verbal complaints.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

Requirement (3)(d)

The Assessment Team found the service was unable to demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. The Assessment Team provided the following evidence relevant to my finding:

* The feedback log shows only three complaints recorded in the six months prior to the Site Audit. Management said only formal complaints are recorded in the feedback log and are often only recorded in progress notes. Management said most feedback was responded to on the spot and did not require further action.
* Management said feedback and complaints are not analysed to identify trends.
* Management was unable to provide an example of when feedback and complaints were used to improve the delivery of care and services.
* The Plan for continuous improvement only included one example of how complaints and feedback had been used to improve the quality of care and services.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

I have considered the intent of the Requirement, which expects that best practice complaints handling and resolution systems are in place to manage feedback and complaints, that this system should be used to improve care and service delivery, that timely feedback should be given to the organisation’s governing body, workforce and consumers on complaints and actions taken, and complaints handling should be regularly reviewed. Evidence in the Assessment Team’s report indicates the service does not meet this expectation, as there are no systems in place to ensure all complaints are recorded and actioned appropriately. Interviews with management shows that trending and analysis of complaints does not occur to identify improvements to care and service delivery.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# Standard 7

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

Findings

Requirement (3)(c)

The Assessment Team found 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. The Assessment Team provided the following evidence relevant to my finding:

* Management and staff confirmed staff have received training in relation to restrictive practices, including what constitutes a restrictive practice, documentation of non-pharmacological interventions, consent and Behaviour support plans. However, staff did not always follow legislative requirements to ensure the use of restraint has been identified for all consumers, it is used minimally and as a last resort, or that informed consent was obtained. All staff interviewed were not knowledgeable that consumers subject to restraint are required to have a Behaviour support plan. While the service’s restrictive practice policy has been updated following changes to legislation, staff confirmed they had not received formal training on the contents following these updates.
* Staff did not undertake pathology of suspected infections, in line with best practice guidelines and the service’s Antimicrobial stewardship policy.
* Staff administered end of life medication to a consumer who was not actively palliating.
* Staff were not documenting and capturing consumer output from their catheter, in line with the service’s policy.
* Staff were not documenting BGLs and notifying the Medical officer in line with a consumer’s diabetic management plan.
* Management said they monitored staff competency and knowledge through observation, peer feedback, spot checks of progress notes and incident review. Management said they do not conduct audits to review staff competency.
* Training documentation did not include a date of completion regarding restrictive practices and antimicrobial stewardship training.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate staff were competent and have the qualifications and knowledge to effectively perform their roles.

I have considered that while the service has processes in place to monitor staff competency, these processes were not effective, as the service failed to identify staff were not providing care and services in line with legislative requirements and the organisation’s policies and procedures. I have also considered that a completion date for staff training is not recorded to enable the service to identify when further training or education is required.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 7 Human resources.

Requirement (3)(e)

The Assessment Team found the service was unable to demonstrate staff are regularly assessed and monitored to ensure they are meeting the expected standard of performance. The Assessment Team provided the following evidence relevant to my finding:

* Management said performance appraisals are undertaken every two years and staff performance is monitored through observation, peer feedback, spot checks of progress notes and incident review. Management said they do not maintain an auditing schedule as a monitoring tool; however, regular training is provided to staff.
* Management said they have not needed to performance manage a staff member in some time, and whilst verbal prompts and reminders have been given, these have not been formally documented.
* Management said improvements to the performance appraisal system were implemented in February 2022 and while staff appraisals following implementation of improvements were documented, those completed prior have not been recorded. Documentation showed only 31.5% of staff have had a performance appraisal completed since February 2022, with none completed since June 2022.
* Management was unable to provide evidence demonstrating there is a process in place to assess and review staff performance during their probationary period.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce.

I have considered the intent of the Requirement which expects the performance of all members of the workforce to be regularly evaluated to identify, plan and support any training and development needs. While the service undertakes performance appraisals, I do not consider a two-year frequency to be ‘regular’ and the service was unable to provide any evidence of evaluation that occurred in between the appraisal cycle. I have also considered the service does not have processes to evaluate the performance of staff during their probationary period to ensure they are performing at an acceptable standard.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(e) in Standard 7 Human resources.

Requirements (3)(a), (3)(b) and (3)(d)

Processes are in place to ensure the number and mix of staffing enables the delivery and management of safe and quality care and services. Consumers and staff considered staffing numbers to be sufficient in meeting consumers’ needs.

Consumers and representatives said staff are kind and caring, and treat consumers with respect. Observations of staff interactions with consumers throughout the Site Audit were consistent with this feedback.

Staff attend regular professional development or training to improve their knowledge, so they can effectively perform their roles. Staff confirmed they are provided training opportunities to perform their role confidently and would talk to their supervisor if they needed additional training or support. Staff confirmed duty statements are in place to guide them in their roles and responsibility. On commencement, buddy shifts are established in addition to formal induction. Recruitment and selection processes include appropriate checks, including police background and qualifications.

Based on the information summarised above, I find the service compliant with Requirements (3)(a), (3)(b) and (3)(d) in Standard 7 Human resources.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | 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

Requirement (3)(a)

The Assessment Team found the service was unable to demonstrate consumers are engaged and supported in the development, delivery and evaluation of care and services. The Assessment Team provided the following evidence relevant to my finding:

* In relation to feedback and complaints, five of 18 consumers interviewed were not satisfied appropriate action is taken in response to complaints, feedback registers did not capture all complaints and Resident meeting minutes for a two-month sampled prior did not capture any suggestions or feedback. The Plan for continuous improvement only captured one improvement identified through feedback and complaints.
* Management said most consumers do not wish to actively engage with them on the development and delivery of care and services.
* A food focus group was initiated to improve the quality of meals and dining experience, however, management said this has been disbanded due to lack of interest.
* Management said they believe the governing body has included some consumers in the evaluation of the kitchen upgrade. The governing body said consumers are informed of the progress, however, there has not been a formal consultation process.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, consumers were not engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

I have considered there is a lack of evidence demonstrating an organisation-wide approach has been implemented to ensure consumer-centred aged care is provided. Where consumer feedback is obtained, such as through feedback and complaints processes, there is no evidence demonstrating the service works with the consumer to fix issues and implement improvements.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 8 Organisational governance.

Requirement (3)(b)

The Assessment Team found 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 that delivery. The Assessment Team provided the following evidence relevant to my finding:

* Agenda items for quarterly governance meetings included strategic planning, workforce, finance, regulatory compliance and business-related risks.
* Agenda items for monthly management meetings demonstrate discussion in relation to the Plan for continuous improvement, duty statements, consumer and staff feedback, and clinical indicators. However, meeting minutes demonstrated limited information documented against each agenda item, such as ‘no unusual trends’ under clinical indicators. One member of the board said while clinical indicators and incidents are not documented, they are communicated (verbally) formally for the purposes of governance meetings and informally as incidents and trends emerge. While the governing body does not include someone with clinical experience, they trust the clinical expertise and judgement of the clinical leadership team to highlight any clinical deficits in care.
* In November 2021, the organisation engaged an external consultant with the aim to identify improvements to care and service delivery. This consultant identified the governing body meeting process was not receiving all critical information and provided education to them on the accountabilities of a governing body. This deficit has been added to the service’s Plan for continuous improvement, however, no actions have been taken in response.
* The consultant also recommended the governing body should have and maintain a diversity action plan to meet the intent of this Requirement, however, the governing body said this has not been undertaken as the current diversity and inclusion policy is sufficient.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the service did not demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for that delivery.

I have considered that while documentation shows the governing body considers a number of items at board meetings, there is no evidence indicating the outcomes of these discussions promote a culture of safe, inclusive and quality care. Minutes of meetings demonstrate the discussions are limited and despite a consultant identifying that governing body meeting processes were not effective in ensuring the board receives all necessary information, no action has been taken to address the deficit.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 8 Organisational governance.

Requirement (3)(c)

The Assessment Team found the service was unable to demonstrate effective organisation wide governance systems in relation to information management, continuous improvement and feedback and complaints. The Assessment Team provided the following evidence relevant to my finding:

* In relation to information management, sampled care plans did not consistently reflect consumers’ needs, goals and wishes, documentation included errors with dates and discrepancies in data captured, staff were unable to run call bell reports to review extended wait times, training records were not up-to-date, meeting minutes and reports have not been consistently completed to include all information and an infections report was not able to be provided.
* In relation to continuous improvement, only one improvement was identified through complaint mechanisms, with the remaining improvements identified through an external contractor and following an investigation undertaken by the Aged Care Quality and Safety Commission. Some improvements had either not been actioned or completed by the assigned date, with management stating they are not sure why they are required.
* In relation to feedback and complaints, management reported only complaints submitted through formal mechanisms are logged on the register. The feedback log showed complaints were not addressed in a timely manner and did not consistently include actions taken to address the complaint.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, governance systems in relation to information management, continuous improvement and feedback and complaints were not effective.

I have considered that members of the workforce did not have access to information that helps them in their roles and ensures consumers are receiving safe and effective care and services in line with their needs and preferences.

I have also considered that while the service maintains a Plan for continuous improvement, improvements were not effectively identified through internal mechanisms and were based solely on those identified by an external consultant and the Aged Care Quality and Safety Commission.

Finally, I have considered that feedback and complaints systems were not effective in ensuring appropriate logging and actioning of complaints.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

Requirement (3)(d)

The Assessment Team found the service was unable to demonstrate risk management systems and practices were effective in relation to management of high impact or high prevalence risks associated with the care of consumers, managing and preventing incidents, and supporting consumers to live the best life they can. The Assessment Team provided the following evidence relevant to my finding:

* Management was unable to provide a risk management framework or policy relating to high impact or high prevalence risks, including monitoring and review of risks, and supporting consumers who choose to take risks.
* Management was unable to provide evidence demonstrating processes are in place to management and prevent incidents.
* The service maintains a high-risk register, however, sections relating to management and evaluation of risks were not completed.
* High-risk meeting minutes sampled did not detail strategies implemented to manage and mitigate risks, and monitor or review the effectiveness of interventions. No high-risk meetings were held between 11 October 2022 and 11 November 2022.
* Clinical indicator reports showed only the number of incidents and did not include consumer names, prevention strategies and evaluation of data.
* Progress note reviews demonstrated all incidents were not logged as incidents in the clinical care system.
* One incident report was identified as being incomplete for a one-month period.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, risk management systems and practices relating to managing high impact or high prevalence risks, managing and preventing incidents, and supporting consumers to live the best life they can were not effective.

I have considered that systems and processes were not in place to support staff in finding ways to reduce or remove risks in appropriate timeframes, ensure evaluation and identification of incidents and near misses to improve the quality of care and services, ensure continued monitoring of risks, and support consumers to take risks to live the best life they can.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

Requirement (3)(e)

The Assessment Team found the service was unable to demonstrate the organisation’s clinical governance framework was effective in ensuring consumers are receiving safe and quality care that meets best practice and legislative guidelines. The Assessment Team provided the following evidence relevant to my finding:

* Clinical indicator reports did not include consumer names or any strategies, interventions or trends at an individual level. In relation to infections, the location, interventions, organism and status was not documented. In relation to restraint, only the number of consumers are documented and there is no evidence of monitoring or management of the use of restraint.
* The high-risk register and high-risk meeting minutes did not include interventions, the effectiveness of interventions, or future actions to monitor and manage clinical risk.
* Monthly management meeting minutes contained limited detail to demonstrate what was discussed or what follow up actions were taken.
* Clinical governance meetings have not been held since 31 August 2022.
* Management said an infection register was maintained; however, it was ceased in July 2022. Reasons for this were not provided. Management said they do not always undertake pathology and their requests to do so are often declined by the Medical officer.
* Infection reports were able to be provided, however, it was not readily accessible and was compiled manually by management on request.
* In September 2022 and October 2022, of the eight and 17 infections recorded, only one and five had pathology undertaken respectively. This is not in line with the organisation’s antimicrobial stewardship policy.
* Medication advisory committee meeting minutes do not include information relating to antimicrobial stewardship.
* All consumers subject to restraint have not been identified or informed consent obtained. Risk assessment forms had not been consistently completed for dignity of risk and there was no evidence indicating restraint was used minimally or as a last resort.
* Behaviour support plans were not reviewed or updated following changes in medication.
* The service does not undertake internal audits in relation to antimicrobial stewardship or restraint. Management said the Clinical nurse will undertake a spot check of progress notes weekly.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Site Audit, the organisation’s clinical governance framework was not effective in ensuring consumers are receiving safe and quality care that meets best practice and legislative guidelines.

I have considered that the organisation’s clinical governance framework was not effective in ensuring good clinical results. Reports used by those responsible for the monitoring and management of clinical risk were not adequate to ensure they had enough information to make decisions about the clinical care provided to consumers and plan to mitigate potential or actual risk. Additionally, internal audits are not undertaken to ensure safe and effective clinical care is provided. I have also considered that the service’s governance processes were not effective in ensuring pathology is undertaken as required prior to administering antimicrobials to ensure appropriate usage. Finally, I have considered the organisation’s governance processes failed to identify restraint was not consistently identified and that regulatory obligations were not being met.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

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