**Phillip R H Chalker Sunset Lodge**

**Performance Report**

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**Commission ID:** 0164

**Provider name:** Crookwell/Taralga Aged Care Ltd

**Site Audit date:** 11 April 2022 to 14 April 2022

**Date of Performance Report:** 3 June 2022

**Performance report prepared by**

Peter Griscti, delegate of the Aged Care Quality and Safety Commissioner.

**Publication of report**

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

**Overall assessment of this Service**

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

**Detailed assessment**

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 Standard and Requirements are assessed as either compliant or non-compliant at the Standard and Requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit undertaken 11 April to 14 April 2022; 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 Site Audit report received 23 May 2022.

**STANDARD 1 COMPLIANT   
Consumer dignity and choice**

**Consumer outcome:**

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

**Organisation statement:**

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

**Assessment of Standard 1**

The Quality Standard is assessed as Compliant as 6 of the 6 specific Requirements have been assessed as Compliant.

The Assessment Team found, overall, that sampled consumers considered they are treated with dignity and respect, can maintain their identity, make informed choices about how their care and services are delivered, and are supported to live how they wish to.

There is documented guidance to support dignity during care delivery, a commitment to diversity and the Assessment Team found that staff are aware of individual consumer needs, goals and preferences relating to their care. Staff described consumers and their needs in a way which demonstrated respect and understanding of individual circumstances. Throughout the Site Audit, the Assessment Team observed respectful and professional interaction between staff and consumers.

Consumers felt supported to take risks which they felt improved quality of life, including independently participating in their communities outside the service, and maintaining habits or activities they enjoyed prior to moving into the service. Staff could describe the risk assessment process and how they support individual consumers.

A sample of consumer documentation demonstrated relevant information about consumer background, culture and life history is captured. The Assessment Team found that consumers, and others they wish to involve, are supported to participate in care planning and felt consulted on their choices and wishes. Consumers also felt that information relating to care and services, such as meal choice, lifestyle and leisure activities and their personal care, was accessible and understandable. Consumers also felt their privacy, and security of personal information, was maintained and respected. Staff could describe how they respect consumer privacy and dignity in practical ways, and the Assessment Team observed this throughout the Site Audit.

**Assessment of Standard 1 Requirements**

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

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

**Requirement 1(3)(b) Compliant**

*Care and services are culturally safe.*

**Requirement 1(3)(c) Compliant**

*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.*

**Requirement 1(3)(d) Compliant**

*Each consumer is supported to take risks to enable them to live the best life they can.*

**Requirement 1(3)(e) Compliant**

*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.*

**Requirement 1(3)(f) Compliant**

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

******STANDARD 2 NON-COMPLIANT  
Ongoing assessment and planning with consumers**

**Consumer outcome:**

1. I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

**Organisation statement:**

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

**Assessment of Standard 2**

The Quality Standard is assessed as Non-compliant as 2 of the 5 specific Requirements have been assessed as Non-compliant.

The Assessment Team found no Requirements under this Standard met. Based on the evidence provided and the Approved Provider’s response to the Site Audit report, I have formed a different view and find the service compliant with Requirements (3)(b), (3)(c) and (3)(d).

Consumers confirmed they were involved in assessment and planning discussions about their care and service needs, however, some said they were not provided with a copy of their care plan or outcomes of assessment. Consumers said people they wish to involve were also included in planning, though this was not always reflected in documentation. Staff appear to be able to easily access care planning and other information required in a timely and easy manner.

The organisation has guidance documentation to support assessment and care planning, however, it is not always followed. Staff were not all able to discuss care planning and assessment processes, noting that most of this is completed by the Care manager/Registered nurse whose role was vacant at the time of the Site Audit. The Assessment Team found that documentation,

The Assessment Team found that while a structured or regular review does generally take place, care planning and assessment were not revisited when consumer needs change, or when incidents impact on consumer condition. Similarly, the Assessment Team found timeframes between assessments for some consumers prescribed psychotropics medications had exceeded the service’s planned timeframe.

**Assessment of Standard 2 Requirements**

**Requirement 2(3)(a) Non-compliant**

*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 were unable to find evidence that assessment and care planning consistently occurs, noting a majority of consumers either lacked an interim care plan or their care plan was incomplete. Examples were provided of consumers who had either delayed and/or an incomplete assessment following admission to the service.

In response, the Approved Provider demonstrated immediate action to complete outstanding assessments for named consumers.

The Assessment Team also provided information under Requirement (3)(b) of this Standard which has influenced my view of compliance with this Requirement. I note for one consumer with changed behaviours, the service could not demonstrate ongoing assessment in the form of charting occurs to inform appropriate care delivery.

I have given weight to positive feedback provided by consumers, being that they are aware of care planning processes, and that staff talk to them about their care. However, I consider that without sufficient documentation, staff are unable to be fully informed of consumer needs, goals and preferences which impact their health and well-being. I have considered that the organisation has documentation to support staff in care planning and assessment (including policy), however, with the service appearing to lack senior clinical staff at the time of (and leading up to) the Site Audit, this crucial aspect of care delivery has been neglected.

On balance, I find the Approved Provider non-compliant with this Requirement.

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

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

The Assessment Team found the service could not demonstrate an opportunity for end of life planning had occurred for all consumers. Similarly, the service was unable to demonstrate ongoing monitoring had occurred for a consumer at risk of absconding.

In response to the Assessment Team’s findings, the Approved Provider notes it has contacted named consumers’ families to arrange for assessment and planning, including documentation of end of life wishes (if desired), to occur.

Based on the evidence provided, I have formed a different view to the Assessment Team. While the Assessment Team identified 2 consumers who didn’t have a (documented) advanced care plan, there is insufficient information to demonstrate whether discussion on this area of planning has or has not been offered to them.

I have also considered feedback that ‘most’ consumers (or their representative) felt they have had an opportunity to communicate end of life wishes. Similarly, feedback from a consulting/external clinical staff member suggests that even in the absence of their own senior clinical staff, discussions about end of life wishes still occur at the service.

In relation to the consumer with insufficient charting, I have considered this matter in relation to Requirement (3)(a) of this Standard and further under Standard 3. While I share the Assessment Team’s concern regarding a lack of documentation, I am of the view this is crucial to inform care delivery by staff in a way that mitigates or minimises risk, rather than it relating to a preference or goal of the consumer as to how their care is delivered.

Accordingly, I find the Approved Provider compliant with this Requirement.

**Requirement 2(3)(c) Compliant**

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

The Assessment Team were not satisfied that the service could demonstrate involvement from others in consumer care planning, citing 2 examples relating to informed consent relating to use of restrictive practices which is further discussed under Standard 3. They also note, for one consumer living with a cognitive impairment, that there was a lack of documentation to show the Public Guardian had been involved with decision making.

I have formed a different view to the Assessment Team based on the information noted under this Requirement and others. Primarily, I place weight on feedback from consumers that they, and/or their representative or others as they wish, are included in assessment and planning, despite whether it is sufficiently documented or not. For example, one consumer noted they like to have their adult child involved in planning, and staff ensure this occurs. There is evidence (both in the Site Audit report and Approved Provider’s response) noting that other health professionals, such as a palliative care consultant, physiotherapist, dentist and dietician, are involved in care planning and assessment, such as through referrals when deterioration or change in health is identified. Further, I note some care plans reference involvement of external organisations/providers which support consumer wellbeing under Standard 4.

Despite a lack of supporting documentation, broad consumer feedback does not suggest consumers, or others whom they nominate, are limited or prevented from being involved in assessment, planning or review of care and service delivery.

In their response, the Approved Provider demonstrated action had been taken to rectify areas of concern raised by the Assessment Team.

Accordingly, on balance of the evidence provided, I find the Approved Provider compliant with this Requirement.

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

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

The Assessment Team found that the service has a process to enable outcomes of assessment and care planning to be effectively communicated to consumers. However, the Assessment Team found this Requirement not met, noting 2 consumers could not confirm if they had been offered or provided a copy of their care plan.

In their response, the Approved Provider advised they had met with, discussed, and provided care planning documentation to named consumers.

In considering the totality of the Assessment Team’s findings, I have come to a different view and find the Approved Provider compliant with this Requirement. I note (based on information provided elsewhere in the Site Audit report) that one named consumer (who was unsure of the contents of, and whether they had a copy of their care plan) provided feedback that staff discuss their care with their adult child. Similarly, while a second consumer was unsure if they had been provided a copy of their care plan, this does not firmly demonstrate the service has failed to provide, or has withheld, a copy from them.

Fundamental to this Requirement; there is evidence that case conferences occur, care plans were readily available to inform delivery of care, and feedback from staff describes how assessment outcomes are communicated to consumers and/or their representatives by a senior clinical staff, although I acknowledge this role is currently vacant.

Accordingly, I find the Approved Provider compliant with this Requirement.

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

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

The Assessment Team found that while there is a planned time frame for review of care plans, a small number of plans viewed by the Assessment Team were overdue for review by several months. The Assessment Team also noted there were lengthy gaps between reviews for a small number of consumers who are prescribed psychotropic medications. The service was also unable to demonstrate that consumer care and service needs were reviewed when incidents occur, including for consumers who had experienced falls.

I have considered positive feedback from representatives that staff generally contact them shortly after a change in condition in consumers is identified and the Assessment Team’s finding that most consumer care plans had been reviewed. However, I give considerable weight to evidence that for 2 consumers, their fall risk assessments had not been reviewed for a considerable period (in excess of 2 years for once consumer) despite them both having multiple falls in recent months.

In their response, the Approved Provider supplied documentation to demonstrate immediate action had occurred for named consumers, however, it is not evident what monitoring or governance mechanisms the Approved Provider has in place to ensure oversight of this process is sustained – irrespective of whether there is a senior clinician at the service or not.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

**STANDARD 3 NON-COMPLIANT  
Personal care and clinical care**

**Consumer outcome:**

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

**Organisation statement:**

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

**Assessment of Standard 3**

The Quality Standard is assessed as Non-compliant as 2 of the 7 specific requirements have been assessed as Non-compliant.

The Assessment Team found Requirements (3)(a), (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) not met. On review of the evidence provided and the Approved Provider’s response, I have come to a different view in relation to (3)(d), (3)(e) and (3)(f) and reasons for these findings are discussed under each Requirement.

While the Assessment Team found that consumers were overall satisfied with the care they receive, the service could not demonstrate that some aspects of care were best practice, nor that it has considered and effectively is able to manage high impact or high prevalence risk relating to consumer care. The Assessment Team found discrepancies in documentation relating to psychotropic medication use and chemical restrictive practices, which management were unable to explain, noting the Care manager/Registered nurse role was vacant at the time of the Site Audit.

Consumers felt they were generally able to access a Medical officer or other health professionals when required, and there was evidence showing the service makes referrals when required. Similarly, the Assessment Team found the service had effective systems in place to support consumers nearing end-of life through transfer to another facility within the same organisation, and a consumer noted they were happy with how the service managed their partner’s care at the end of their life.

In relation to identifying and acting appropriately to deterioration, review of a consumer’s file demonstrated that while some aspects could be improved, overall the service acted appropriately. Consumers noted the service is responsive to changes, and staff were able to discuss escalation processes when they identify a change in consumer condition or deterioration.

The service overall demonstrated an effective infection and prevention and control program and implemented precautions to minimise and prevent risk of infection. The Assessment Team observed staff undertaking infection prevention and control measures throughout the duration of the Site Audit, however, some minor breaches were observed. Staff could describe action within the remit of their roles which support good antimicrobial stewardship practices.

**Assessment of Standard 3 Requirements**

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team identified gaps relating to wound management. I have considered that the issues raised are more relating to documentation and general staff practice rather than to how the service addressed wounds for specific consumers, however, have considered this in relation to other Standards. Based on the information presented, I note consumers with skin integrity concerns or wounds appear to have wounds regularly reviewed and addressed, and the service has had a small number of pressure injuries in recent months which have resolved. In their response, the Approved Provider outlined their intended actions in relation to wound management protocols and staff training to ensure best practice.

The Assessment Team also identified issues relating to informed consent not being obtained in a clear nor timely manner for use of psychotropic medications, including for a consumer who is unable to make their own decisions. In their response, the Approved Provider provided evidence to demonstrate this matter is being addressed. Similarly, multiple discrepancies were noted between the service’s psychotropic medication register and individual consumer care documentation for a significant number of consumers. Service management noted this was under the remit of the former Care manager and a full review of the register and consent documentation would be undertaken.

The Assessment Team identified that one consumer who absconded from the service did not have their wandering behaviours nor risk of absconding noted on in care documentation including their Behaviour support plan, however, it is not made clear if the absconding risk existed or was known prior to the incident occurring. Notwithstanding, it is not evident that the service updated documentation in a timely manner following the incident.

I have considered feedback from consumers presented in the Site Audit report that they are pleased with the care they are receiving, in addition to staff comments which demonstrates they are familiar with the needs of individual consumers. However, it is not evident that all consumers are receiving care that is best practice, particularly in relation to use requirements for use of psychotropic medication has high potential to diminish quality of life and wellbeing.

Accordingly, based on the information provided I find the Approved Provider non-compliant with this Requirement.

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

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

The Assessment Team found that while the service has systems in place to manage risk relating to consumer care, including policies and procedures to guide staff practice following a consumer falling, they had not been followed. Examples demonstrated where staff had failed to follow aspects of relevant organisational policy and procedure following incidents, including updating relevant assessments and notifying Medical officers.

Similarly, the Assessment Team found discrepancies in administration of schedule 8 medication which was acknowledged by management as not following best practice.

I have considered that staff were able to describe strategies to mitigate what the service considers high impact or high prevalence risk to their consumers, namely falls and unplanned weight loss. Similarly, staff were able to refer to service policy or procedure. However, the examples provided by the Assessment Team show a departure from the expected practice and an apparent lack of managerial oversight to ensure discrepancies are identified and addressed.

Accordingly, based on the information provided I find the Approved Provider non-compliant with this Requirement.

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

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

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

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

The Assessment Team found this Requirement not met, based on assessment of the service’s actions following an incident where a consumer became unwell. However, I have formed a different view to that of the Assessment Team.

In the example provided, I note the service took actions to monitor the consumer’s condition throughout the period in which they became unwell with fever-like symptoms, including regular observations, urinalysis to identify whether a urinary tract infection was the cause of illness, rapid antigen testing, contacting a Medical officer and contacting an ambulance. Ultimately, the consumer remained on site as their condition was deemed stable by paramedics. Further information regarding the consumer’s illness/outcomes is not provided. While the service acknowledged there could have been improvements in the timeliness of this consumer’s review, I am of the view, prima facie, that the service took reasonable actions which were relevant to the level of deterioration experienced by this consumer.

In their response the Approved Provider provided evidence of training provided to staff relating to deterioration. I have also considered feedback from consumers who note responsiveness from staff in relation to change in condition, and staff feedback that they are aware of escalation processes.

Accordingly, I find the Approved Provider compliant with this Requirement.

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

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

The Assessment Team were not satisfied that the service meets this Requirement, noting that care and services documentation reviewed was inadequate to provide handover of consumer needs and preferences. Two examples have been provided, including one relating to a consumer’s lack of an appropriate substitute decision maker. While this demonstrates a departure from best practice, I am of the view that this does not specifically relate to information sharing to enable delivery of day to day care needs.

I have considered, with reference to findings under Standard 2 Ongoing assessment and planning, that there are improvements required in relation to documentation. The deficiencies presented by the Assessment Tea have been considered in other Requirements.

However, I am of the view that examples provided throughout the Site Audit report demonstrate there is some information documented and shared to support delivery of consumer needs and preferences, including through the electronic care planning system. I have considered feedback from staff which outlines how they receive and share information, that they can demonstrate familiarity with individual needs, and feedback from consumers who feel that staff know them and their needs well.

Accordingly, based on the information provided, I find the Approved Provider compliant with this Requirement.

**Requirement 3(3)(f) Compliant**

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

The Assessment Team found the service did not make timely referrals for consumers for further assessment following incidents and provided examples relating to consumer falls where the service did not contact Medical officers, and in one case a physiotherapist in a timely manner.

In forming a position, I have also considered that at the time of the Site Audit, the service had limited senior clinical expertise on site. Accordingly, where there are incidents, I consider it reasonable that outside assistance could, or should be sought. Management noted there is not a specific policy for making referrals to other health professionals, rather, these are embedded within other policies and procedures.

However, I also note feedback from a clinical staff in relation to involving other health professionals when needed, and documentation relating to specialist healthcare appointments and use of dieticians where weight loss is identified. Notably, for consumers at end of life, the organisation refers/transfers them for more specialist care at their other service. Feedback from consumers included that they have access to Medical officers and/or other health professionals when it is required.

Accordingly, prima facie, I find the Approved Provider compliant with this Requirement.

**Requirement 3(3)(g) Compliant**

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

The Assessment Team found the service has systems in place to minimise infection related risks, including practices to support or promote appropriate prescribing and use of antibiotics. However, the Assessment Team noted these practices were not consistently followed and they additionally identified a number of minor breaches relating to infection prevention and control.

Consumers provided feedback that they observed staff to always wear personal protective equipment and perform hand hygiene. The Assessment Team documented generally positive observations relating to staff practice and infection prevention and control during the Site Audit, however, they observed a small number of breaches, including relating to mask use and use of shared equipment (such as phones and computers) without cleaning between use. The service acknowledged areas raised by the Assessment Team during the Site Audit and noted they would follow up with staff.

Despite the above, I have considered there is evidence of staff understanding in relation to broad infection prevention practices and all staff interviewed noted they have completed infection prevention and COVID-19 training. The Assessment Team note the service has a suite of policies and procedures in relation to infection control and antimicrobial stewardship.

While it is noted 2 consumers were prescribed antibiotics without awaiting pathology results, I am unable to ascertain, in the absence of further information, why this has occurred. There is, however, evidence that staff consider and test for common infections, and while some staff may not have been fully familiar with the term antimicrobial stewardship, they could describe practical ways in which they promote and support care and reduce reliance on antibiotics.

Accordingly, on balance on the information provided, I find the Approved Provider compliant with this Requirement.

**STANDARD 4 COMPLIANT   
Services and supports for daily living**

**Consumer outcome:**

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

**Organisation statement:**

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

**Assessment of Standard 4**

The Quality Standard is assessed as Compliant as 7 of the 7 specific Requirements have been assessed as Compliant.

The Assessment Team recommended all Requirements in this Standard as met. While the Approved Provider submitted a response to the Assessment Team’s Site Audit report, correspondence did not specifically relate to this Standard.

The Assessment Team found most sampled consumers felt they get the services and supports for daily living which are important for their health and well-being and enable them to do the things they want to do.

Consumers overall said they felt supported by the service to do the things they enjoy, and felt the service supported them to ‘have a purpose’. Care planning documents appeared to include relevant and accurate information about consumers and what they enjoy, and staff appeared to have a solid understanding of consumer lifestyle needs and interests.

The Assessment Team viewed the lifestyle program which appeared to contain a variety of activities and cater for broad interests. Consumers are engaged in driving the program which is reviewed using feedback from Resident/relative meetings and surveys. The Assessment Team also observed staff engaged in activities with consumers of varying functional and cognitive ability throughout the Site Audit.

Consumers discussed how staff supported their emotional, spiritual and psychological wellbeing, and care planning documentation included information related to individual consumers. Similarly, consumers felt supported to participate in their communities both within and outside the home and examples demonstrated how the service considers ways to meet individual needs.

The service demonstrated how it effectively documents and shares information relating to consumer condition, needs and care preferences. The Assessment Team found care plans show evidence of updates relating to services and supports for living which support effective care and staff could explain how they ensure they have contemporary knowledge relating to individual consumers.

Consumers were happy with meals provided by the service, noting there are options, the menu changes regularly, and they have input into changes. The Assessment Team noted that care plans reflected consumer needs and preferences, and the kitchen and dining area appeared clean and tidy.

**Assessment of Standard 4 Requirements**

**Requirement 4(3)(a) Compliant**

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

**Requirement 4(3)(b) Compliant**

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

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

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

**Requirement 4(3)(d) Compliant**

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

**Requirement 4(3)(e) Compliant**

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

**Requirement 4(3)(f) Compliant**

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

**Requirement 4(3)(g) Compliant**

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

**STANDARD 5 COMPLIANT   
Organisation’s service environment**

**Consumer outcome:**

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

**Organisation statement:**

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

**Assessment of Standard 5**

The Quality Standard is assessed as Compliant as 3 of the 3 specific Requirements have been assessed as Compliant.

The Assessment Team found the service meeting all Requirements under this Standard. While the Approved Provider submitted a response to the Assessment Team’s Site Audit report, correspondence did not specifically relate to this Standard.

Consumers said they felt comfortable, safe, and satisfied with the service environment; that is was clean and well maintained. They were pleased they could personalise their own living spaces and felt their guests are welcomed by the service when they visit. The Assessment Team noted consumer rooms to reflect individual interests and character.

The Assessment Team observed the living environment of the service to be clean, well maintained and welcoming, and supportive of consumers with varying levels of mobility. Similarly, equipment and furniture for consumer use appeared clean, appropriate and well maintained.

The service was able to demonstrate there are proactive and reactive maintenance processes for plant and equipment, and staff could discuss processes relating to maintenance and cleaning. Consumers felt equipment was well maintained and any issues addressed promptly when they arise. However, the Assessment Team did note that the call bell system was not regularly checked with a considerable gap in time since the last audit. In response, management undertook a full audit and added this to the service’s monthly preventative maintenance program.

**Assessment of Standard 5 Requirements**

**Requirement 5(3)(a) Compliant**

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

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

*The service environment:*

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

**Requirement 5(3)(c) Compliant**

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

**STANDARD 6 NON-COMPLIANT  
Feedback and complaints**

**Consumer outcome:**

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

**Organisation statement:**

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

**Assessment of Standard 6**

The Quality Standard is assessed as Non-compliant as one of the 4 specific Requirements have been assessed as Non-compliant.

The Assessment Team did not find the service meeting Requirements (3)(c) and (3)(d), however, I have come to a different view to that of the Assessment Team in relation to (3)(c) and have provided reasoning in the specific Requirement below.

The Assessment Team found, overall, that consumers were satisfied that they could provide feedback and make complaints in a manner that works for them. Consumers were happy to share their views on care and service delivery; are provided opportunities to discuss their care in both public and private forums, and have access to supports such as advocates, language supports and other external services if they are required.

Staff were able to describe how they support consumers when they need to provide feedback, and there is written documentation to support consumers and guidance for staff, including relevant policy and procedure.

It was not evident, however, that the service has robust oversight of feedback and complaints and uses them to inform continuous improvement opportunities within the service. While consumers confirmed action is taken in response to complaints, it was not evident the service utilises an open disclosure process, nor are there examples to demonstrate it used when the service self-identifies something that hasn’t gone the way it should have. It is not evident that the service has strong processes for monitoring or trending complaints such that they can be used to identify potential continuous improvement opportunities.

The service does have relevant policy and procedure relating to the Requirements under this Standard, however, it was not demonstrated that they are well understood, nor is it clear there are robust governance mechanisms to support continuous improvement.

**Assessment of Standard 6 Requirements**

**Requirement 6(3)(a) Compliant**

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

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

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

**Requirement 6(3)(c) Compliant**

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team found that whilst complaints raised by consumers were resolved, sampled staff were unfamiliar with the concept of open disclosure and its use.

Staff interviewed stated they had not received specific training on open disclosure, which I have considered further under Standard 7 in relation to staff training. In their response, the Approved Provider supplied information to demonstrate that action was underway in this regard. I also note the service’s feedback policy and procedure includes links to information on open disclosure, despite staff being unfamiliar with the concept.

However, in forming a view of compliance against this Requirement, I have given weight to feedback provided by consumers being that issues and/or complaints have been acted upon by the service in a prompt manner. Further, it is noted that that the service is prompt to contact representatives when there is a change in consumer condition or in response to an incident. Although further information about staff’s subsequent actions is needed to confirm, this is a key component of an open disclosure approach. No representative feedback has been presented regarding use of open disclosure or sentiment relating to complaint processes.

Accordingly, prima facie, I find the Approved Provider compliant with this Requirement.

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

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

The Assessment Team noted the service was unable to demonstrate review of feedback and subsequent changes or improvements being made. Documentation relating to feedback and complaints (and actions taken by the service) prior to commencement of the incumbent Chief executive was unable to be sourced during the Site Audit.

In forming a position, I have relied on feedback from consumers and a small number of service personnel. Two consumers note they attend Resident committee meetings to have their say in how the service has run, but neither were able to describe changes which had occurred as a result of their input. Similarly, the organisation’s Quality Lead was unable to contribute information to support how the service understands and applies this Requirement in delivery of care. One example of an improvement in relation to food temperature was presented by a staff member, however it is unclear when this improvement was implemented.

Although generally positive feedback regarding the feedback and complaints process has been provided by consumers throughout the Site Audit report, this Requirement seeks to determine service posture in relation to continuous improvement and it is expected that the service demonstrates how feedback, whether positive or negative, is used to improve quality of care and services in an ongoing manner. While feedback alludes to some consumer involvement in design and delivery of care (for example, regular food forums to discuss meal services), there is a lack of evidence, by way of documentation and examples, to demonstrate how the service captures, analyses, trends and/or uses feedback to inform improvements in care and service delivery.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

**STANDARD 7 NON-COMPLIANT  
Human resources**

**Consumer outcome:**

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

**Organisation statement:**

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

**Assessment of Standard 7**

The Quality Standard is assessed as Non-compliant as 4 of the 5 specific Requirements have been assessed as Non-compliant.

The Assessment Team found the service unable to demonstrate that the workforce is planned with sufficient numbers of staff to support the delivery and management of care and services. At the time of the Site Audit, the service Care manager/Registered nurse role was vacant, with some of the management team working off site, which appears to have contributed to deficiencies in the Human resources function and performance at the service.

Limited direct managerial oversight has impacted other aspects of care and service delivery. When queried about certain aspects of care or service delivery or about their understanding of the Quality Standards, some care staff were unfamiliar and noted the areas of questioning was within the remit of more senior staff. I have considered that the service has been lacking in its oversight of staff training, ensuring competence and managing performance, based on the Assessment Team’s testing of staff knowledge and alignment to findings under other Requirements, such as assessment and planning processes which fail to adequately capture individual consumer needs.

However, consumer feedback about staffing, including staff conduct, has been overall positive, and the Assessment Team’s observations were consistent with sentiment that staff are kind, caring, and treat consumers as individuals with dignity and respect.

**Assessment of Standard 7 Requirements**

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

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

While the Assessment Team contend that most consumers felt there were insufficient staff numbers, few examples have been provided which demonstrate a detrimental impact to consumer care and service delivery as a result. While one consumer noted a 15-20 minute wait in response to a call bell, the Assessment Team were unable to verify this as the service was unable to demonstrate any call bell monitoring process had occurred for a significant time. In their response, the Approved Provider advised call bell monitoring would be recommenced.

At the time of assessment, the service lacked a Care manager/Registered nurse due to a recent resignation. In their response, the Approved provider has advised this position has been filled with a new staff member commencing shortly after the Site Audit.

While lack of a Registered nurse has not been explicitly linked to an adverse outcome for consumer(s), information has been presented under other Requirements which highlights the inherent risk in this workforce situation, including relating to administration of specific medications by other staff members who may not possess the necessary knowledge or experience, nor are acting within the scope of their practice or aligned to the Approved Provider’s mediation management policy. I also note at the time of the Site Audit, the service lacked a trained Infection prevention and control (IPC) lead as required by the Commonwealth Department of Health, although it is noted the incoming Care manager/Registered nurse would be nominated to this position upon commencement.

I have also considered that no information has been presented as to how the service determines an appropriate mix and number of staff, how the workforce is planned to address staff shortages (both planned and unplanned, and/or in the event of an internal or external emergency), and how the Approved Provider monitors and responds to changing needs of consumers through adjustment of staff numbers.

While feedback about quality of staff and their conduct has been consistently positive throughout the Assessment Team’s report, at the time of the time of the Site Audit, a system for ensuring there are sufficient numbers of staff to deliver consistently safe delivery of care and services is not evident. Accordingly, I find the Approved Provider non-compliant with this Requirement.

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

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

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

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

Consumers interviewed during the Site Audit felt staff had sufficient skills and knowledge to deliver their care needs. However, feedback from staff highlighted areas in which they believe they require further training which is consistent with the areas of care delivery (and Requirements) in which the Assessment Team have recommended that the home are not meeting to a sufficient standard.

In forming a view of compliance against this Requirement, I have considered the information volunteered by staff that they feel they require further training/support from the service (specifically in medication administration), that at least one example has occurred where staff were proactive in seeking training where they feel a need for it (rather than the Approved Provider monitoring and determining training needs), and feedback from one staff that the service has been lax is providing requested training in some areas of care and service delivery.

I have also considered the information presented under Standard 3 Personal and clinical care in relation to medication administration and wound documentation, in addition to evidence under Standard 6 Feedback and complaints relating to staff understanding of open disclosure.

While incidents noted within the Site Audit report have not been explicitly linked to staff competence and may be the result of multiple factors, it is incumbent on the Approved Provider to proactively demonstrate how they ensure staff are competent and have the knowledge to perform their roles. Particularly with the absence of a Care manager/Registered nurse resulting in higher-level duties falling on other staff, it is critical that the service retains effective and proactive oversight of staff competence. It has not been sufficiently demonstrated that this is occurring within the service.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

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

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

Similar to consumer views on workforce competence, the Assessment Team found consumers felt staff were well trained to provide care and did not raise any specific areas in which they felt staff required further training. However, I have considered the information volunteered by staff in relation to training received and identified training needs, including that some staff felt the service provided insufficient training in some areas of care delivery and others were still waiting after making a request.

Of note, there are areas in which staff stated they had not received training and were unfamiliar, including open disclosure and antimicrobial stewardship. Some staff also raised that they felt they did not have sufficient training nor felt competent to administer medication to consumers. The Assessment Team sighted some documentation relating to induction and mandatory training which staff are required to undertake, however it was not evidenced that this had occurred at the time of the Site Audit. In their response, the Approved Provider supplied further details in relation to mandatory training.

While there is an online training provider engaged by the service, evidence of training records was not provided. Staff confirmed they are provided some training through this platform and there are mandatory topics requiring annual completion.

In the absence of a Care manager/Registered nurse at the time of the Site Audit (this position has subsequently been filled), it is not evident steps were taken to support other staff to act at a higher level and ensure continuity of care and service delivery.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

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

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

The Assessment Team found the service unable to demonstrate that regular assessment, review and monitoring of staff performance had been undertaken, including that the service had not followed organisational policy in relation to formal performance appraisals.

In their response, the Approved Provider noted a transition to new procedures and policies from mid-2022, however, no information was provided relating to action or progress in undertaking overdue appraisals. No evidence or discussion of informal monitoring and review mechanisms has been presented in the Assessment Team’s report or Approved Provider’s response.

I have considered the feedback raised by management that that there had not been any negative feedback received regarding staff performance, however, in considering the totality of information presented regarding staff knowledge and competence, I am of the view information has been presented by staff which suggests the service has been lax in monitoring and identifying opportunities for improvement in staff skills and practice. Management noted consumer surveys and feedback is used to inform potential training needs, however, no evidence or examples of this has been undertaken in relation to individuals or groups of staff.

Further, feedback from staff has included information about requests they have made in relation to learning and development. While it is positive to note that some staff have been proactive and responsible for their own development, it raises the question whether there are certain topics or knowledge deficiencies across the entire workforce which would potentially be identified if staff had the opportunity to have regular performance discussions with their manager(s).

The Assessment Team note management are satisfied with staff performance, however, examples have been presented throughout the Site Audit report which demonstrate some areas where staff do not possess the knowledge, nor have been adequately supported, to deliver care consistent with the requirements of the Quality Standards.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

**STANDARD 8 NON-COMPLIANT  
Organisational governance**

**Consumer outcome:**

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

**Organisation statement:**

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

**Assessment of Standard 8**

The Quality Standard is assessed as Non-compliant as 4 of the 5 specific Requirements have been assessed as Non-compliant.

The Assessment Team found no Requirements under this Standard met, however, I have formed a different view in relation to Requirement (3)(a) and have provided reasons under the specific Requirement.

While consumers generally felt the organisation was well run, the service was unable to demonstrate robust governance frameworks to support safe and effective delivery of care and services, and processes that that demonstrate accountability for understanding and application of the Quality Standards. Some opportunities were evident where consumers could be involved in development and delivery of care.

There has been limited demonstration of effective organisation-wide governance systems for continuous improvement, regulatory compliance, workforce governance and information management. Further, while there are some examples of how the service monitors and manages risk, significant work remains to demonstrate integrated and effective risk management systems and corresponding practices.

**Assessment of Standard 8 Requirements**

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

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

The service asserted that it meets this Requirement and provided a small number of examples during the Site Audit, however, the Assessment Team were not provided with supporting documentation and recommended this Requirement as not met. The Assessment Team also noted limited opportunity to obtain evidence in how the service meets this Requirement due to a lack of access to key senior staff.

However, I have noted a small but broad range of examples throughout the Site Audit report which suggest consumers and their representatives are engaged and supported (to a degree) to be involved various aspects of care design, delivery and evaluation, including in relation to care planning, meals and the service environment and their individual living spaces. For example, it is noted that consumers are engaged in the ongoing lifestyle program/schedule which is shaped using feedback from Resident/relative meetings and surveys.

Further, while there is a lack of evidence demonstrating how the service utilises feedback for continuous improvement (discussed under Standard 6 Feedback and complaints), a majority of consumer feedback suggests that staff are engaged with consumers to address their concerns in a way that is satisfactory to them. Similarly, I have considered that the Assessment Team recommended, and I subsequently found, that the service is delivering services and supports for daily living, and there are examples which show how consumers are engaged in delivery of care and services – including feedback from one consumer who commented that their involvement makes them feel like they ‘have a purpose’.

Accordingly, prima facie, I find the Approved Provider compliant with this Requirement.

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

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

The Assessment team note the service was unable to provide sufficient evidence in how they demonstrate understanding and application of this Requirement, including lack of a risk identification or mitigation system and lack of evidence of audit data being provided to the governing body.

Limited evidence of the governing body’s involvement in care design, delivery or monitoring can be obtained through other Standards and there is an apparent lack of mechanisms demonstrating accountability. In their response, the Approved Provider notes new governance processes will commence from 1 July 2022.

In forming a position on the service’s compliance with this Requirement, I have considered several examples where service management and/or the governing body have failed to act to ensure continuity of care, which include not addressing/covering a senior role before a new Care manager/Registered nurse had commenced, staff not having regular performance appraisals as an opportunity to raise training requests or needs, lack of structured call bell monitoring and failure to recognise issues relating to medication administration/staff working outside the scope of their practice.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The Assessment Team were not satisfied the service could demonstrate effective governance systems to support delivery of care and services, relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

In their response, the Approved Provider notes that new governance mechanisms will be implemented from 1 July 2022, however, did not provide further comment.

In relation to information management, I have considered that there appear to be systemic care planning and assessment deficiencies which prevents staff from accessing timely, contemporary and relevant information relating to consumer care need. For example, almost three quarters of consumers at the time of the Site Audit lacking an interim care plan or having an incomplete care plan, and the Assessment found incomplete, or outdated assessments/documentation for consumers with known risks such as falls. I have also considered that the service was unable to consistently produce documentation for viewing during the Site Audit to support multiple statements or findings made across multiple Quality Standards.

Based on the information provided under Standard 6, the service has not demonstrated a governance system relating to feedback, complaints and continuous improvement. It is not evident how oversight of complaints occurs and/or subsequent actions and improvements are monitored.

Some evidence has been provided in relation to workforce governance and regulatory compliance, specifically relating to checking minimum qualifications for staff and mandatory annual training, which are undertaken during recruitment and orientation. Similarly, it was advised there is a system for checking registered staff have a current professional registration.

However, no governance system or structure was demonstrated in relation to other areas of workforce governance, such as ensuring the service has an IPC lead aligned to Department of Heath requirements, that staff are acting within the scope of their professional practice or that the service ensured shifts are consistently covered.

No evidence has been provided as to how the service ensures its regulatory obligations are being consistently met, such as being assured it is reporting serious incidents where appropriate, or ensuring it is understanding and accurately applying the requirements relating to Behaviour support planning.

Accordingly, based on the evidence provided I find the Approved Provider non-compliant with this Requirement.

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team were not satisfied the organisation was able to demonstrate effective risk management systems and practices in relation to managing and preventing incidents, including the use of an incident management system, identifying and responding to abuse and neglect of consumers and managing high impact or high prevalence risks associated with the care of consumers. They found staff were unable to demonstrate a sound understanding relating these areas, nor was evidence provided to demonstrate how the service reviews incidents and adjusts care and service delivery or practices to prevent reoccurrence. In their response, the Approved Provider notes new governance processes will commence from 1 July 2022.

The Assessment Team were advised quality indicators and incidents are reviewed at clinical leadership meetings, however, were not provided with examples to support this. Similarly, that management monitor risk by relying on the information documented in the electronic documentation system. Further, no evidence has been provided which shows how management seek assurance that the information is accurate, or comprehensive, and no examples have been provided as to how the organisation uses this information to improve care and services.

In relation to managing high impact or high prevalence risks associated with the care of consumers, I have considered the evidence documented under Standard 3 to support my view that the service does not have effective risk management processes, as it is not evident there was sufficient or appropriate actions taken following falls and there is a lack of clinical oversight relating to medication management.

I have considered that staff undertake mandatory training regarding abuse and neglect and reporting of serious incidents, however, the Assessment Team note that staff were generally unaware of relevant policies and unable to provide examples of how they understand and apply this knowledge to their role.

I have also taken consumer feedback documented throughout all Standards into account and do consider that the service demonstrates a commitment to supporting consumers to live their life as they wish. It is evident that staff know consumers as individuals and treat them accordingly, including striving to deliver their needs and preferences – irrespective of whether these matters are comprehensively documented or not.

Accordingly, on balance of the information provided, I find the Approved Provider non-compliant with this Requirement.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The Assessment Team note that the service has policies and procedures relating to antimicrobial stewardship, minimising restraint and open disclosure, however, found limited staff knowledge in these areas which is addressed under other Requirements. No further information has been provided in relation to practical governance processes, such as how the service documents, monitors, analyses or trends information relating to clinical matters. In their response, the Approved Provider noted new governance processes will commence from 1 July 2022.

I have considered the information documented under other Standards in forming my view, including that some staff were able to describe practical ways in which they prevent infection and there is evidence that testing occurs on most occasions to determine infection status prior to antibiotic use. Further, the Assessment Team note the organisation has a suite of policies and procedures in relation to antimicrobial stewardship and staff knew where to access them. However, minimal information has been presented how the organisation monitors or tracks use of antibiotics at a governing level; while I note the organisation collect quality data in relation to infections, there was no evidence presented how the organisation uses this data from a continuous improvement perspective. Further, there has been no discussion how staff are made aware of consumers with infection, and no demonstration how the organisation assures itself that antimicrobials are prescribed according to best practice guidelines. It is not evident if the service utilises outside expertise or a multi-disciplinary/holistic approach (for example, drawing on Pharmacists or Medical officer involvement) to promote and strive for best practice.

In relation to minimising use of restrictive practices, robust oversight and an effective framework is not evident which has resulted in multiple documentation discrepancies for consumers who are prescribed a psychotropic medication, including relating to consistent capture of informed consent. Similarly, while the service has demonstrated some understanding of chemical restrictive practices, it has not been demonstrated how it ensures they are used only as a last resort and in compliance with relevant legislation.

In relation to open disclosure, the Assessment Team found staff understanding to be poor and it was not evident if/where the service has used an open disclosure process in response to self-identified deficiencies in care or service delivery. I have considered that at the time of the Site Audit there was an apparent lack of senior clinical/managerial oversight and while all staff might be expected to have a baseline understanding of open disclosure, actual practice in response to an incident might generally fall within the remit of this managerial/leadership role. I have also considered that the offsite Quality lead noted no involvement in review of complaints or feedback, which could have been a second component of a practical framework to ensure open disclosure is used. Further, if, as suggested, reported incidents are reviewed by the clinical leadership meeting, it is not evident whether this is also utilised as a final check that the service is using open disclosure where appropriate. Subsequently, I am of the view that while there may be multiple potential components to form an effective framework, these opportunities have not been utilised by the service or organisation.

Accordingly, on balance of the evidence presented, I find the Approved Provider non-compliant with this Requirement.

**Areas for improvement**

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

**Requirement 2(3)(a) Non-compliant**

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

The approved provider must demonstrate:

* Assessments and care plans include risks associated with the consumers care and related mitigation strategies.
* Assessment and care plans care are completed in a timely manner upon consumer admission to the service. Care plan review and updates occur in a timely manner when new risks are identified.
* Documentation accurately and comprehensively reflects individual needs.

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

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

The approved provider must demonstrate:

* Documented needs are regularly reassessed, including when incidents or circumstances may impact or change those needs.
* Consumers’ care and services are regularly reviewed for effectiveness when consumer incidents occur, including relating to falls, behavioural and skin injury incidents.

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The approved provider must demonstrate:

* Consumers personal and clinical care is tailored to their needs and optimises their health and well-being, specifically relating to behaviour management, management of restrictive practices, and falls.
* Informed consent is obtained and documented in a timely manner.
* Pharmacological interventions in response to behaviours of concern are used as a last resort with other strategies trialled prior and effectiveness consistently measured.
* Appropriate monitoring is undertaken following incidents and interventions applied by the service.

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

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

The approved provider must demonstrate:

* Organisational policy and/or procedure is followed, including relating to post-incident protocols.
* Staff act within the scope of their practice, including relating to medication administration.

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

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

The approved provider must demonstrate:

* Feedback and complaints are regularly reviewed and used to pursue continuous improvement of care and service delivery.

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

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

The approved provider must demonstrate:

* A robust strategy for ensuring staffing mix is sufficient, including ensuring presence of appropriate clinical staff and a trained infection prevention and control lead aligned with relevant requirements.

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

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

The approved provider must demonstrate:

* Staff are competent, credentialed and acting within the scope of their role, particularly in relation to medication administration.

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

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

The approved provider must demonstrate:

* Staff are supported, including through training, to deliver the care and services required of them.

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

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

The approved provider must demonstrate:

* Staff performance is monitored and reviewed regularly, whether through formal or informal means, or a combination of both.

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

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

The approved provider must demonstrate:

* The governing body is accountable for the delivery of safe, inclusive and quality care and can demonstrate how they are involved in the design, delivery and monitoring of care aligned with the Quality Standards.

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The approved provider must demonstrate:

* Organisational governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints are reviewed and understood by staff, including regular monitoring and oversight of these areas by the governing body.

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

*Effective risk management systems and practices, including but not limited to the following:*

The approved provider must demonstrate:

* Systems for incident and risk management, including compliance with serious incident reporting, are robust and effective.
* Personnel (including management) have a thorough understanding of their obligations in these areas and mastery of an effective incident management system.
* Effective oversight of the risk management system to identify when risk controls need to be reviewed.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The approved provider must demonstrate:

* Clinical oversight mechanisms reviewed and able to be effective, including in relation to coordinated efforts to minimise restraint, ensure a high standard of antimicrobial stewardship, and consistent practise of open disclosure.
* The Clinical Governance Framework effectively guides the practice of staff and staff can demonstrate these practices in their day to day work.