Regis Port Coogee

Performance Report

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**Commission ID:** 7469

**Provider name:** Regis Aged Care Pty Ltd

**Site Audit date:** 2 August 2022 to 4 August 2022

**Date of Performance Report:** 30 September 2022

# Performance report prepared by

M Glenn, 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

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Non-compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Non-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) | Non-compliant |
| Requirement 2(3)(d) | Non-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** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Non-compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-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) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Non-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) | Non-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; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others;
* the provider’s response to the Site Audit report received 5 September 2022; and
* the Performance Report dated 19 January 2022 for the Assessment Contact – Site undertaken on 24 November 2021.

# STANDARD 1 NON-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 Non-compliant as two of the six specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(a), (3)(c) and (3)(e) in Standard 1 Consumer dignity and choice not met. The Assessment Team were not satisfied the service demonstrated:

* each consumer is treated with dignity and respect or personal and clinical care is provided in a way that supports their dignity;
* all consumers are effectively supported to make decisions about their care or that family are involved in decisions about how care should be delivered; and
* information provided to consumers is current, timely and communicated in accordance with their needs.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(a) and (3)(c) and Compliant with Requirement (3)(e). I have provided reasons for my findings in the specific Requirements below.

In relation to all other Requirements in this Standard, the Assessment Team found consumers are recognised as individuals with their own history and traditions associated with their culture. These aspects of care were reflected in consumers’ individualised care plans and through organisational policies and procedures. There are processes to monitor consumers’ diversity to ensure specific cultural needs are being met. However, the Assessment Team noted the service heavily relies on assistance from families and representatives, rather than embedding strong communication strategies that care staff can use to provide consumers care and services that are culturally safe.

## Consumers confirmed they are able to make decisions about how they wish to live their life. Where a consumer chooses to engage in an activity with an element of risk, consultation with consumers and/or representatives occurs and risk assessments are completed outlining risks involved, contributing factors and actions to mitigate the risk. However, staff adherence to risk assessment plans is not consistently monitored. This has been further considered under Standard 2 Ongoing assessment and planning with consumers Requirement (3)(a) and Standard 3 Personal care and clinical care Requirement (3)(b), specifically in relation to Consumer E.

## There are processes to ensure consumers’ privacy is respected and information is kept confidential. Staff practices were observed to respect consumer privacy.

Based on the Assessment Team’s report, I find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Compliant with Requirements (3)(b), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

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

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

The Assessment Team were not satisfied the service demonstrated each consumer is treated with dignity and respect or personal and clinical care is provided in a way that supports their dignity. The Assessment Team’s report provided the following evidence relevant to my finding:

* Ten consumers and representatives provided recent examples of where personal care needs had not been attended to, care provided was not respectful and clinical needs had not been managed resulting in a loss of dignity. Examples included a consumer being found on numerous occasions to be malodorous with hair unwashed and in clothes that did not appear to have been changed; a consumer often found unkempt, unshaven and malodorous and sitting on dirty sheets; a hospital wrist band which had been in place since the consumer returned from hospital eight days prior resulting in impaired skin integrity; a consumer observed wearing soiled clothing; and a staff member observed not to respond to a consumer’s call for help.
* A staff member was observed removing a television remote control from a consumer who was turning up the television to a volume so they could hear. The staff member turned the sound down and put the remote control behind the nurse’s station desk. The consumer was heard saying they could no longer hear the television.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* In relation to one consumer, there is documented evidence of refusal of personal care, evaluation of ongoing refusals and recommended strategies in their care plan. There is evidence of personal care needs being undertaken and ongoing discussion and correspondence with the representative about improvements taken in response to their concerns.
* In relation to another consumer, there is documented evidence about refusal of care and the representative attended a care plan consultation in April 2022 where this was discussed.
* In relation to the wrist band, an open disclosure process was undertaken at the time of discovery and the service had a transparent and learning approach to the incident.
* In relation to the television remote, there is no further information provided about the staff’s response to the consumer’s feedback or whether there were other consumers’ needs the staff member was responding to.

I acknowledge the provider’s response and associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not ensure each consumer was treated with dignity and respect, with their identity, culture and diversity valued. In coming to my finding, I have placed weight on feedback provided by consumers and representatives indicating consumers have not been consistently treated with dignity and respect and the resulting impacts this has had on consumers.

In coming to my finding, I have considered that the service’s monitoring processes have not been effective in identifying the staff practices observed which has impacted on consumers’ personal experience. And while I acknowledge the provider’s response indicating for two consumers, refusal of care has been discussed with representatives, I have considered the feedback received from these representatives demonstrates strategies initiated have not been effective and the representatives remain dissatisfied. The service should seek to implement processes to ensure they work with consumers and/or representatives in an inclusive and respectful way and listen to and understand each consumer’s personal experience as it relates to the way care and services are being provided to them.

In relation to the consumer with the wrist band, Consumer B, I have considered that the evidence presented in this Requirement does not demonstrate the service has failed to treat the consumer with dignity and respect. Rather, the evidence presented specifically relates to provision of personal care. As such, I find the evidence provided aligns with Standard 3 Personal care and clinical care Requirement (3)(a) and have considered the information with my finding for that Requirement.

For the reasons detailed above, I find Requirement (3)(a) in Standard 1 Consumer dignity and choice to be Non-compliant.

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Non-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.*

The Assessment Team were not satisfied the service demonstrated all consumers are effectively supported to make decisions about their care or that family are involved in decisions about how care should be delivered. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer A and their representative were not involved in a decision to prescribe a medication for the intention of modifying changed behaviours.
* Two representatives stated although they have informed the service the consumers want their involvement and assistance in making decisions about care, the service does not always contact them when decisions are being made.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* A Restraint assessment and authorisation document for Consumer A was commenced before an internal review concluded the prescription of the medication did not constitute chemical restraint. The document was archived following discussion with the representative in July 2022. The medication was prescribed in December 2020 and the consumer’s family were advised of the prescription on the same day.
* In relation to one consumer, there is specific reference to the representative successfully acting as their advocate. Thirteen care plan consultations have been conducted since entry, with the representative participating in most of these.
* For another consumer, there is documented evidence refusal of personal care, evaluation of ongoing refusals and recommended strategies in their care plan. Regis acknowledge there could have been further collaboration with the representative in the case of these refusals.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, each consumer was not supported to exercise choice and independence. I have considered that this has not ensured consumers and/or representatives have been provided options and information to support their choice.

In relation to Consumer A, I have considered that sufficient information was not provided to the consumer and representative in relation to a medication prescribed. Supporting documentation included in the provider’s response indicates that while the representative had been informed of the prescription of the medications, other key elements relating to use of restrictive practices, in line with the organisation’s policies and procedures, had not been disclosed.

I find the two representatives highlighted have not been consistently involved in decisions relating to the care and services the consumers receive. For one consumer, this has resulted in their wishes relating to how they want care not being effectively communicated. For another consumer, progress notes demonstrate the consumer regularly refuses to accept assistance with personal care. However, while representatives indicated they have instructed staff to call them when the consumer refuses care, they stated staff never call.

For the reasons detailed above, I find Requirement (3)(c) in Standard 1 Consumer dignity and choice to be Non-compliant.

### 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.*

The Assessment Team were not satisfied the service demonstrated information provided to four consumers and representatives was current, timely and communicated in accordance with their needs. The Assessment Team’s report provided the following evidence relevant to my finding:

* A representative was provided with a restrictive practice management plan that contained descriptions of Consumer A’s changed behaviours that had not been discussed with the consumer or representatives.
* A representative stated they never received satisfactory information in relation to the outcome of an investigation into an incident involving Consumer B.
* A representative stated they were not informed Consumer C was to receive a vaccination which resulted in the consumer receiving a double dose and an incident form indicated Consumer D had been administered a vaccination without consent being obtained.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* Acknowledge use of the term “behaviours” may have been ambiguous when referencing the consumer’s symptoms and this appears to have caused confusion between staff and family until it was cleared up during consultation in July 2022.
* Management met with Consumer B’s representative to discuss the incident. It is acknowledged there was a missed opportunity for ongoing communication with the representatives about the review that occurred.
* The two vaccination incidents were reported once identified, with an open disclosure approach initiated and appropriate steps implemented to prevent recurrence, including new processes relating to consent.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. In coming to my finding, I have considered information in the Assessment Team’s report across the eight Quality Standards which demonstrates consumers and/or representatives are provided information through various avenues, including noticeboards, newsletters, meeting forums and care plan review processes. As such, I find this demonstrates information about the care and services offered is provided.

In relation to Consumers A, B and D, I have considered that the evidence presented does not suggest information provided is not current, accurate and timely or is not communicated in a way that is clear, easy to understand and enables consumers to exercise choice. Rather, the evidence presented for Consumer A specifically relates to supporting consumers to exercise choice and independence and for Consumers B and D, using an open disclosure process when things go wrong. As such, I have considered the evidence and the provider’s response for Consumer A in my finding for Requirement (3)(c) in this Standard and for Consumers B and D, Requirement (3)(c) in Standard 6 Feedback and complaints. In relation to Consumer C, I acknowledge the provider’s response.

For the reasons detailed above, I find Requirement (3)(e) in Standard 1 Consumer dignity and choice to be Compliant.

### 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:

### 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 four of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met. The Assessment Team were not satisfied the service demonstrated:

* assessment and planning, including consideration of risks to consumers’ health, informs the delivery of safe care and services;
* assessment and planning is based on ongoing partnership with consumers and others the consumer wishes to involve in assessment;
* outcomes of assessment and planning are effectively communicated to consumers and documented in a care and service plan that is readily available to the consumer; and
* care and services are reviewed regularly for effectiveness, and when circumstances change or incidents impact on the needs of the consumer.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(a), (3)(c), (3)(d) and (3)(e). I have provided reasons for my findings in the specific Requirements below.

In relation to Requirement (3)(b) in this Standard, consultation with consumers and representatives and assessment and planning processes identify and address consumers’ needs, goals and preferences, including advance care planning and end of life planning. Most care files sampled included advance care plans outlining consumers’ cultural and physical wishes when at the end of life phase. The palliative care team were observed visiting with a consumer and liaising with registered staff to incorporate their assessment into the consumer’s care plan.

Based on the Assessment Team’s report, I find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Compliant with Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers.

## 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 not satisfied the service demonstrated assessment and planning, including consideration of risks to consumers’ health, informs the delivery of safe care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer E self-administers medications, however, the plan does not include the requirement to monitor the medication and includes incorrect information relating to the level of assistance and type of medication self-administered.
* A risk assessment has not been undertaken nor strategies identified following an incident in May 2022 to reduce risk to the consumer’s safety.
* Consumer F’s behaviour management plan does not include clear interventions to support management of changed behaviours identified in July 2022.
* Plans to protect Consumer G’s skin from deterioration were not effective and a wound deteriorated over a period of time.
* Consumer K’s behaviour care plan is so complex that staff are not effectively managing their behaviour**.**

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The incident in May 2022 was the only incident of this nature where Consumer E did not notify staff. A care plan consult occurred, with no changes required.
* Care plans in place support inclusive and comprehensive strategies and communication tools to support Consumer F in maintaining dignity, quality of life and referral specialist review while working in partnership with representatives.
* Consumer G’s wound deteriorated despite optimal ongoing wound care prevention and management, including regular assessment and review, implementation of wound management and prevention strategies, appropriate specialist consultation and oversight by the General practitioner.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate assessment and planning processes were effectively implemented to ensure assessment and planning was personalised and reflective of consumers’ current needs. I have considered that this has not ensured each consumer’s care plan is tailored to their specific needs or informs how, for each consumer, care and services are to be delivered.

In relation to Consumer E, I have considered that while a risk assessment had been completed, the care plan did not include the requirement for staff to monitor the medication, resulting in the consumer having access to more medications than agreed to in the risk acknowledgement form. Additionally, care plan information is not congruent with the care the consumer is receiving. In relation to the incident in May 2022, I accept the provider’s response indicating this was an isolated incident and find appropriate follow up, including incident reporting, occurred post the incident.

In relation to Consumer F, I have considered that while the physical behaviour care plan is extensive, behaviours have been identified and triggers and behaviour management strategies are documented. I have further considered behaviour management strategies, including review and sufficiency in my finding for Requirement (3)(e) in this Standard.

In relation to Consumer G, I have considered the Assessment Team’s evidence and provider’s response in my findings for Requirement (3)(e) in this Standard and Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care.

In relation to Consumer K, while I acknowledge that specific behaviours directed towards another consumer had been identified, I have considered that the behaviour management care plan did not clearly outline behaviour management strategies specifically related to this behaviour directed towards the consumer who was the target in all three incidents. I do acknowledge that following the last incident in March 2022, no further incidents of this nature had occurred.

For the reasons detailed above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers to be Non-compliant.

### 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.*

### Requirement 2(3)(c) Non-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 the service demonstrated assessment and planning is based on ongoing partnership with consumers and others the consumer wishes to involve in assessment. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumers and representatives stated they used to be able to discuss care with Clinical team leaders, but as these staff have left they are rarely consulted regarding the care and services consumers receive.
* Four representatives stated they had not been involved in the ongoing planning and review of consumers’ care.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* A robust clinical leadership structure is in place and there are many systems to support clinical assessment and review for consumers with representative involvement as they like. There are also many systems to ensure representatives are aware of who the team is and how to escalate concerns.
* The Assessment Team’s information is factually incorrect based on Consumer A’s clinical documentation.
* There is documented evidence of refusal of personal care, evaluation of ongoing refusals and recommended strategies in Consumer C’s care plan. Regis acknowledge there could have been further collaboration with the representative in the case of these refusals.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, assessment and planning processes were not consistently based on ongoing partnership with the consumer and/or representatives. In coming to my finding, I have placed weight on feedback from consumers and representatives indicating they did not feel like partners in the ongoing assessment and planning of consumers’ care and services. As such, I find this has not ensured consumers are supported and encouraged to make decisions about the care and services they receive and the way they are delivered.

For the reasons detailed above, I find Requirement (3)(c) in Standard 2 Ongoing assessment and planning with consumers to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated outcomes of assessment and planning are effectively communicated to consumers and documented in a care and service plan that is readily available to the consumer. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer A’s representative had not been informed of the outcome of a behavioural assessment that identified changed behaviours.
* A representative indicated they were no longer aware who the General practitioner overseeing the consumer’s care was and they did not get any updates about the management of the consumer’s chronic conditions.
* Three representatives were not aware that clinical staff they had been communicating with, in order to keep up-to-date with the outcomes of assessments and clinical issues, had left the service. Emails had gone unanswered and they had not been able to contact the staff by phone.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The Assessment Team’s information is factually incorrect based on Consumer A’s clinical documentation.
* Progress notes were provided demonstrating consultation between the representative and General practitioner.
* There are many systems to support clinical assessment and review for consumers with representative involvement as they like. There are also many systems to ensure representatives are aware of who the clinical and management team is and how to escalate concerns.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, outcomes of assessment and planning were not effectively communicated to the consumer and and/or representative.

I acknowledge the provider’s response indicating there are many systems to support consumers’ and representatives’ involvement in clinical assessment and review. However, in coming to my finding, I have considered feedback from three representatives indicating they were not aware clinical staff they had communicated with in order to keep up-to-date with the outcomes of consumers’ assessments and clinical care no longer worked at the service. I find this does not demonstrate consumers and/or representatives have been involved in discussions relating to consumers’ care and service provision nor has it enabled them to have an understanding and ownership of the care plan.

For the reasons detailed above, I find Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated care and services are reviewed regularly for effectiveness, and when circumstances change or incidents impact on the needs of the consumer. The Assessment Team’s report provided the following evidence relevant to my finding:

* An Allied health directive for Consumer H, from July 2022 was not reviewed for effectiveness. Consumer H had a further two falls whilst the directive was in place.
* Consumer E’s risk assessment plan relating to medication management was not reviewed for effectiveness.
* Despite regular wound care, Consumer G did not have effective reassessment undertaken leading to development of an unstageable wound.
* Consumer F did not have interventions relating to changed behaviours trialled before they were added to the care plan resulting in further incidents causing harm.
* Consumer F had two falls in June and July 2022. The Falls risk assessment was last updated in January 2022.
* Following an incident directed towards another consumer, a risk assessment was not undertaken to identify further risks nor were management strategies reviewed for effectiveness.
* Consumer I’s progress notes from April 2022 to July 2022 show ongoing skin integrity issues relating to continence management indicating management plans are not being followed.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* There is no evidence to suggest the Allied health directive relating to bed height was not being followed by staff.
* Following missed medications in July 2022, a risk assessment was created and strategies agreed with Consumer E’s family. A care plan evaluation was due in August 2022. When it was identified at the Site Audit that the consumer had more medications than required, an evaluation then occurred.
* Consumer G’s wound deteriorated despite optimal ongoing wound care prevention and management, including regular assessment and review, implementation of wound management and prevention strategies, appropriate specialist consultation and oversight by the General practitioner. The consumer’s compounding comorbidities and refusal of pressure relieving strategies significantly impacted wound healing.
* Consumer F was reviewed by a range of qualified health care professionals regarding behaviours. The treatment plan and medications prescribed were altered accordingly by the General practitioner following appropriate escalation and suggested management strategies from specialist services were implemented with effect.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not ensure care and services were regularly reviewed for effectiveness in response to changes in consumers’ care and service needs, specifically in relation to Consumers G, F and I.

In relation to Consumer G, I acknowledge the provider’s response indicating the consumer’s compounding comorbidities and refusal of pressure relieving strategies significantly impacted wound healing. However, while the consumer’s wound was noted to have deteriorated in April 2022, there is no indication risk assessments or current management strategies were reviewed for effectiveness or new strategies implemented. Risk assessments relating to use of a wheelchair and refusal of a pressure relieving device and repositioning included in the provider’s response were dated January and February 2022 respectively.

In relation to Consumer F, I have considered that following an incident involving another consumer, behaviour management strategies were not reviewed for effectiveness. Behaviour care plans provided do not demonstrate review occurred following the incident and strategies directly related to the behaviour displayed are limited. I have also considered that while new strategies were added to the care plan following feedback from the Assessment Team, these strategies had not been tested or evaluated for effectiveness prior to implementation.

In relation to Consumer I, I have considered that despite ongoing skin integrity issues related to continence care, there is no indication continence management strategies have been reviewed or new strategies trialled in response.

As such, I find for Consumers G, F and I, such practices have not ensured care plans are up-to-date or that care and services delivered are in line with consumers’ current needs and preferences or that risks to consumers are minimised.

In relation to Consumer H, the evidence presented by the Assessment Team and the provider’s response does not indicate the height of the bed contributed to the consumer’s falls.

In relation to Consumer E, I have considered that the evidence presented in this Requirement does not relate to review of care and services. Rather, the evidence presented specifically relates to provision of clinical care. As such, I find the evidence provided aligns with Requirement (3)(b) in Standard 3 Personal care and clinical care and have considered the information with my finding for that Requirement.

For the reasons detailed above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers to be Non-compliant.

# 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 two of the seven specific Requirements have been assessed as Non-compliant.

Requirements (3)(a) and (3)(b) were found Non-compliant following an Assessment Contact undertaken on 24 November 2021, where it was found the service did not demonstrate:

* each consumer received personal or clinical care which was best practice, tailored to their needs or optimised their health and well-being, specifically in relation to continence needs; and
* effective management of high impact or high prevalence risks, specifically in relation to pain, medication and behaviour.

The Assessment Team found the organisation/service had not successfully implemented improvements to address the previous findings of non-compliance and these deficits remain.

At the Site Audit, the Assessment Team recommended Requirements (3)(a), (3)(b), (3)(d) and (3)(e) not met. The Assessment Team were not satisfied the service demonstrated:

* best practice and care is tailored to consumers’ needs, specifically in the delivery of wound and continence care, and personal care has not been attended as per the wishes of consumers and representatives;
* effective management of high impact or high prevalence risks. specifically medication administration, falls, wounds and choking risks;
* deterioration or change of a consumer’s physical function is recognised and responded to in a timely manner; and
* effective communication about consumers’ needs and preferences is documented and shared.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(a) and (3)(b) and Compliant with Requirements (3)(d) and (3)(e). I have provided reasons for my findings in the specific Requirements below.

In relation to all other Requirements in this Standard, the service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. Consumers are provided an opportunity to discuss wishes relating end of life through advance care planning. A care file for one consumer included an advance care plan outlining their physical, cultural and spiritual wishes regarding end of life care and their family were encouraged to remain with the consumer, in line with their wishes. Specialist palliative care services were noted to have been involved in the consumer’s care and their recommendations followed.

Timely referrals to individuals, other organisations and providers of other care and services were generally demonstrated through care files sampled. However, for three consumers, recommendations made in response to referrals were noted to have not been consistently implemented.

The service implements minimisation of infection related risks and practices standard and transmission-based precautions. Pathology testing is undertaken before antibiotic therapy is administered. All staff are trained in infection control and minimisation of the spread of infection, and staff demonstrated an understanding of precautions required to minimise the spread of infection.

### Based on the Assessment Team’s report, I find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Compliant with Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### 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.*

Requirement (3)(a) was found Non-compliant following an Assessment Contact undertaken on 24 November 2021, where it was found the service did not demonstrate each consumer received personal or clinical care which was best practice, tailored to their needs or optimised their health and well-being, specifically in relation to continence needs. The Assessment Team found the organisation/service had not successfully implemented improvements to address the previous findings of non-compliance and these deficits remain.

At the Site Audit, the Assessment Team were not satisfied the service demonstrated best practice and care is tailored to consumers’ needs, specifically in the delivery of wound and continence care. Personal care has not been attended as per the wishes of consumers and representatives. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer G’s wounds were not treated according to best practice guidelines and the wound became unstageable requiring surgical intervention. Additionally, recommendations relating to fluid intake were not followed and the consumer’s fluid intake goal was not maintained.
* Personal care was not attended to for Consumers L, C and O resulting in them being left unshowered and unkempt, sometimes for days at a time.
* A hospital band was left on Consumer B’s wrist for eight days resulting in a wound which was identified by the family. Additionally, representatives feel they have to visit daily to ensure Consumer B’s care and clinical needs are met.
* A nutritional supplement recommended by an Allied health specialist in July 2022 for Consumer I had not been commenced.
* Wound treatments have not been consistently undertaken in line with the wound management plan with the wound described as infected.
* Safe continence care was not provided to maintain skin health. The consumer has an injury related to continence management.
* Wound specialist’s notes indicates a stage 2 pressure injury was identified. The consumer was observed sitting with pressure on the area, not in line with the specialist’s directive.
* Consumer J’s time sensitive medications (patch) were not given on six occasions between May and August 2022 as the pharmacy was out of stock. The General practitioner was notified in August 2022 and oral medications were arranged in the interim. Risks to the consumer’s well-being had not been considered or further strategies/interventions implemented. No incident reports relating to the missed medications had been completed.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* Consumer G’s wound deteriorated despite optimal ongoing wound care prevention and management, including regular assessment and review, implementation of wound management and prevention strategies, appropriate specialist consultation and oversight by the General practitioner.
* There is documented evidence of Consumers L and C’s refusal of personal care, evaluation of ongoing refusals and recommended strategies in their care plan. There was ongoing discussion and correspondence with the representatives relating to improvements taken in response to concerns. Regis acknowledge they could have worked more collaboratively with the consumers and/or representatives in response to these refusals.
* Reject the claim Consumer O has not been provided with appropriate standards of personal care. Progress notes for two days in August 2022, during the Site Audit, were provided to demonstrate personal hygiene had been attended.
* In relation to Consumer B, an open disclosure process was undertaken at the time of discovery and the service had a transparent and learning approach to the incident.
* Acknowledge and accept lack of evidence of Consumer I’s nutritional supplement not being commended, noting there was no impact to the consumer as a result. Consumer I frequently refuses when prompted and offered assistance with continence care, exacerbating excoriation. Acknowledge and accept the opportunity in relation to staff prompting continence aid changes in line with the frequency required in the care plan.
* Acknowledge improvement opportunities relating to medication management systems. Acknowledge Consumer J did not receive medicated patches for a three day period, however, received their oral medication. Actions were initiated when supply issues relating to the patches were identified.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, each consumer was not provided safe and effective personal and/or clinical care which was best practice, tailored to their needs and which optimised their health and well-being, specifically in relation to provision of personal care, skin integrity, wound management, medication management and nutrition and hydration.

In relation to Consumer G, I find recommended strategies to optimise the consumer’s health and well-being were not appropriately undertaken with a recommendation to encourage fluids to minimise the consumer’s risk of infection not followed. Fluid intake charting for an eight day period demonstrated on all eight days, the consumer’s fluid intake was well below that recommended, and records sampled for a one month period showed the consumer had not consumed the recommended intake on any of the days.

In relation to Consumer G’s wound management, I find wound management plans, included in the provider’s response, do not provide a clear description of the progression of Consumer G’s wound. The first indication in the Wound review section that the wound was black and necrotic is in May 2022, 14 days after the wound is noted as necrotic in the Comments section of the same document. Three notations in the wound review section between these dates contradict the April 2022 notation with the wound described as red and granulating. Additionally, while a General practitioner notation in April 2022, specific to the wound, indicate the wound had deteriorated over the previous two week period, this deterioration is not noted in the management plan notations. Entries in the Wound review section documented during this two week period describe the wound as red and granulating; in the Comments sections, there are only two entries which describe the area as inflamed. As such, I find wound management processes have not ensured care that is best practice or tailored to the consumer’s needs.

In relation to Consumers L, C and O, while I acknowledge the provider’s response indicating Consumers L and C refuse care and recommended strategies are in place, I find these strategies have not been effective in ensuring a high standard of personal care is attended. Additionally, feedback provided by representatives indicates they are not confident Consumers O and B’s personal care is consistently met. I have also considered feedback provided by staff highlighted in Standard 1 Consumer dignity and choice Requirement (3)(a), Standard 7 Human resources Requirement (3)(a) and the Consumer summary outcome for Consumer F which indicates personal care is not being consistently provided to consumers in line with their assessed needs and/or preferences. Specifically, several consumers in one wing did not have continence aids changed in line with care plans; consumers are not being provided appropriate care; consumers are provided a wash instead of a shower; and creams to maintain skin integrity are not usually applied. All of the feedback was aligned with sufficiency and mix of staff. As such, I find personal care was not tailored to consumers’ needs or provided in a way which optimised their health and well-being

In relation to Consumer B, I find staff failed to undertake the consumer’s personal care in a manner which ensured skin integrity was monitored and changes identified and escalated. As such, this resulted in a wound being identified by representatives under a hospital wrist band which had been left in place for eight days following return to the service.

In relation to Consumer I, I have considered that whilst an Allied health recommendation in July 2022 indicated a nutritional supplement should commence in response to unplanned weight loss, this had not been implemented. Additionally, I have considered that wound treatments have not been consistently undertaken in line with the frequency documented in the wound management plan for a wound described as infected. I find such practices do not effectively enable wound progression to be monitored and wound deterioration to be identified in a timely manner to ensure appropriate actions are taken accordingly. I also find staff failed to undertake the consumer’s personal care in a manner which ensured skin integrity was monitored and changes identified and escalated. A wound was identified at stage 2 and recommendations to minimise the risk of pressure injuries were observed not to have been followed. Furthermore, I find continence management has not been adequate to ensure changes to the consumer’s skin integrity is maintained. The consumer has had ongoing skin integrity issues related to continence management for approximately three months.

In relation to Consumer J, I find medication management processes have not ensured adequate supply of the consumer’s time-sensitive medications which had the potential to impact on the consumer’s health and well-being. While I acknowledge the General practitioner was notified and alternative measures implemented, this did not occur until three doses of the medication had been omitted. Risks to the consumer’s health as a result of the missed medications had not been considered.

For the reasons detailed above, I find Requirement (3)(a) in Standard 3 Personal care and clinical care to be Non-compliant.

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

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

Requirement (3)(b) was found Non-compliant following an Assessment Contact undertaken on 24 November 2021, where it was found the service did not demonstrate effective management of high impact or high prevalence risks, specifically in relation to pain, medication and behaviour. The Assessment Team found the organisation/service had not successfully implemented improvements to address the previous findings of non-compliance and these deficits remain.

At the Site Audit, the Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks, specifically in relation to medication administration, falls, wounds and choking risks. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer B’s wound treatments had not been consistently undertaken in line with the management plan resulting in the wound deteriorating over a seven day period.
* Consumer E, who self-administers medication, was able to stock pile medication and did not have the correct quantity of medication as agreed to on a risk acknowledgement form.
* Consumer G’s wound deteriorated and was not treated effectively until the wound was black and necrotic and required surgical intervention.
* Consumers F and K have ongoing incidents of changed behaviour that has a high impact risk on other consumers and their safety. Behaviour care plans are so complex that staff are not effectively managing their behaviour.
* Allied health recommendations for thickened fluids have not been followed for Consumer I and staff sampled did not know if the consumer required thickened fluids.
* Consumers H, B, L and J, all at risk of falls, have not been effectively managed, including post incidents.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* There is no evidence Consumer B’s wound deterioration related to lack of care.
* Following missed medications in July 2022, a risk assessment was created and strategies agreed with Consumer E’s family. A care plan evaluation was due in August 2022 and when it was identified at the Site Audit that the consumer had more medications than required, an evaluation then occurred.
* Acknowledge and accept identified improvements relating to the isolated error regarding medication and the need to ensure a robust checking process, with changes implemented post the Site Audit.
* Consumer G’s wound deteriorated despite optimal ongoing wound care prevention and management, including regular assessment and review, implementation of wound management and prevention strategies, appropriate specialist consultation and oversight by the General practitioner.
* Consumer F’s care plans were reviewed following all incidents. Following an incident in June 2022, a referral was initiated and review undertaken by specialist services and recommendations incorporated into the care plan. Behaviour care plans include dates of evaluation.
* Consumer K was involved in three behavioural incidents directed toward another consumer in March 2022. As a result of effective and ongoing behaviour management strategies, there were no further incidents between the consumers.
* Consumer I’s nutritional supplement was for the purpose of weight gain, not swallowing/choking risk.
* There is no evidence to suggest the Allied health directive was not followed relating to Consumer H’s bed height. Following two incidents in July 2022, Consumer B was reviewed by the Registered nurse, relevant care plans evaluated, referrals initiated and actions implemented to determine root cause. An incident report was not lodged following an incident involving Consumer L, however, the consumer was assessed by the Registered nurse following the incident. In relation to consumer J, there was detailed review and investigation following both incidents.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, effective management of high impact or high prevalence risks were not demonstrated, specifically in relation to management of wounds, medications, swallowing and falls.

In relation to Consumer B, I have considered that wound treatments have not been consistently undertaken in line with the frequency documented in the wound management plan with the wound deteriorating over a seven day period. As such, I find staff practices did not ensure the wound was effectively monitored to enable additional measures or changes to the management plan to be implemented to aid wound healing. In relation to falls management, supporting documentation included in the provider’s response demonstrates appropriate actions were initiated post falls, including clinical observations, pain charting, head to toe assessment, referral to Allied health and notification to the General practitioner and evaluation of care plans for falls risk and mobility occurred. However, the entry is limited to ‘care plan has been evaluated’. There is no indication that the effectiveness of strategies was considered nor that additional strategies to minimise the consumer’s risk were implemented. Subsequent review of the consumer’s falls risk was undertaken and new management strategies implemented in response to feedback from the Assessment Team.

In relation to Consumer E, I find agreed upon medication management strategies have not been effectively implemented, resulting in the consumer accumulating a supply of medications which was not in line with risk management documentation. The provider’s response indicates a risk assessment relating to the consumer’s self-administration was implemented following representatives’ disclosure of a medication incident involving the consumer. As such, the service should have ensured that the agreed to strategies were undertaken, which included weekly monitoring of the consumer’s medication. I have also considered that the consumer’s medications were observed not to be appropriately stored. As such, I have considered strategies to minimise risks to the consumer and other consumers have not been effectively implemented.

In relation to Consumer G, I acknowledge supporting documentation included in the provider’s response to demonstrate regular General practitioner and Wound specialist input. However, wound management documents, included in the provider’s response, indicate the wound was noted to have deteriorated, with the wound described as necrotic, in April 2022. However, supporting documentation indicates Wound specialist input did not occur until 15 days later and a General practitioner review did not occur until nine days later. In June 2022, the wound required surgical intervention. As such, I find that the wound was not adequately monitored, characterised or timely specialist interventions sought when the wound was noted to have deteriorated.

In relation to Consumer F, I have considered the consumer’s behaviours had been identified. While three incidents relating to aggression were noted between May and June 2022, there is no indication that management strategies to minimise the impact of the behaviours on the consumer and others were not implemented in response on each occasion. In relation to an incident in July 2022, while risk assessments were not implemented, I have considered that appropriate measures were initiated, including a monitoring/sighting chart and behaviour chart. While this particular behaviour was known, with reference to the behaviour noted in a care plan included in the provider’s response, there is no indication that the behaviour was displayed on a frequent basis or that there was an ongoing risk to other consumers**.** However, I have considered that behaviour management strategies were not reviewed following each incident and strategies for one particular behaviour were not clearly evident. As such, I have considered this evidence and the provider’s response in my finding for Standard 2 Ongoing assessment and planning with consumers Requirement (3)(e).

In relation to Consumer K, I have considered the consumer’s behaviours had been identified and a behaviour management plan was in place. The Assessment Team’s report indicates that following at least two of the three incidents, appropriate actions were taken in response, including a pain assessment, head to toe assessment, delirium screen, referral to the General practitioner and arrangements made for a family meeting. However, I have considered that the behaviour management care plan does not clearly outline behaviour management strategies related to this behaviour towards the consumer who was the target in all three incidents. As such, I have considered this evidence and the provider’s response in my finding for Standard 2 Ongoing assessment and planning with consumers Requirement (3)(a).

While the Assessment Team indicated behaviour care plans for Consumers F and K were complex, the evidence presented does not demonstrate the consumers’ behaviours were not effectively managed, however, I find this has the potential to impact the effectiveness and implementation of behaviour management strategies.

In relation to Consumer I, I have considered Allied health recommendations in response to risks related to the consumer’s swallowing impairment have not been consistently implemented. The provider asserts the nutritional supplement recommended was for the purposes of weight gain and not swallowing/choking risk. However, the Assessment Team’s report indicates thickened fluids were initiated in June 2021 in response to a swallowing impairment. Observations made by the Assessment Team indicate the consumer is not consistently provided fluids at the consistency recommended and staff sampled were unaware of this requirement, potentially placing the consumer at risk.

In relation to Consumer H, the evidence presented by the Assessment Team and the provider’s response does not indicate the height of the bed contributed to the consumer’s falls.

In relation to Consumer L, I acknowledge the provider’s response. In relation to an incident form not being completed, I have considered this evidence and the provider’s response in my finding for Requirement (3)(d) in Standard 8 Organisational governance.

For Consumer J, I have considered that despite the consumer having two falls within eight days, management strategies were not reviewed or new management strategies identified to minimise the consumer’s risk of falls. Documentation included in the provider’s response indicates appropriate actions were initiated post falls, including Allied health reviews. A notation following the first fall is limited to the falls risk and mobility care plans ‘has been evaluated’; there is no evidence of an evaluation occurring following the second incident. Additionally, the falls risk assessment had not been updated in response to the falls with the most recent assessment dated in January 2022.

For the reasons detailed above, I find Requirement (3)(b) in Standard 3 Personal care and clinical care to be Non-compliant.

### 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 were not satisfied the service demonstrated deterioration or change of a consumer’s physical function is recognised and responded to in a timely manner. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer G’s wound deteriorated to a large unstageable wound which required surgical intervention. Staff did not recognise the wound deterioration and seek assistance with treatment prior.
* Despite low oxygen saturation readings and signs of distress, staff did not recognise Consumer M’s deteriorated condition or think they needed medical assistance. The representative took the consumer to hospital under their own fruition due to their concern about the consumer. The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:
* Staff appropriately recognised, escalated and followed up accordingly when deterioration was first identified. There was regular and ongoing review by external specialists, General practitioner, Nurse practitioner and Physiotherapist.
* Commentary and supporting documentation from the time a change in Consumer M’s condition was identified to when the consumer was taken to hospital. While staff recommended an ambulance be called, the representative took the consumer to the hospital.

I acknowledge the provider’s response. Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement.

In relation to Consumer G, I have considered the evidence presented relates to management of high impact or high prevalence risk and, as such, have considered the evidence and the provider’s response in my finding for Requirement (3)(b) in this Standard.

In relation to Consumer M, supporting documentation in the provider’s response demonstrates appropriate actions were taken in response to a change in the consumer’s condition, including review by a Nurse practitioner, regular monitoring of the consumer’s oxygen saturation levels and application of oxygen in response to readings. Progress notes provided do not indicate the consumer was in distress. When staff were informed of a new symptom by the representative, appropriate actions were initiated.

For the reasons detailed above, I find Requirement (3)(d) in Standard 3 Personal care and clinical care to be Compliant.

### 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 the service demonstrated effective communication about consumers’ needs and preferences is documented and shared. Care plan alerts are not always used to alert staff of consumers’ needs and other important information is not always readily available for them. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer H had an electronic alert regarding the bed height. The consumer continued having falls due to staff not being aware of the information. The information was not included in the consumer’s care plans.
* An agency care worker stated they had received a verbal handover of all the consumers in the area they commenced work, but then they were moved to another area. The staff member was unaware there were mobility care plans located in consumers’ rooms.
* Staff were unable to identify why weekly weights are undertaken for Consumer C or when they would need to escalate a weight increase as there was no instruction visible in the consumer’s care record.
* Consumer F’s extended care plan is very long and does not provide staff with clear, concise information regarding care related to behavioural changes. Three agency staff said they did not know the consumer or have any information about their behavioural needs.
* Consumer I was recommended dietary supplement drinks which were not commenced as recommended by the Dietitian.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* Evidence supports Consumer H’s bed height being correct, including at the time of the falls.
* Agency staff have access to an electronic care system which is used for all consumers. The orientation process for agency staff has been reviewed.
* Progress notes for Consumer C which included rationale for weighs and when to report to the General practitioner.
* Consumer F had a detailed behaviour care plan that included recommendations and strategies which has been printed and shared with care staff. There is clear evidence of staff implementing recommended strategies and interventions.
* Acknowledge and accept lack of evidence of nutritional supplement not being commenced for Consumer I, noting there was no impact to the consumer as a result.

I acknowledge the provider’s response. Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement.

In relation to Consumer H, while information relating to bed height was not included in care planning documentation, there is no evidence to suggest that these directives were not known by staff nor that the incidents which occurred related to the bed not being at the correct height.

While agency staff were not aware of care requirements for Consumer F, I have considered that agency staff have access to consumer information through the electronic care management system. I acknowledge the provider’s response indicating agency staff orientation processes have been reviewed and improvements to the handover process implemented.

In relation to Consumer C, progress notes from June 2022, included in the provider’s response, clearly highlight the rationale for weight monitoring. Directives relating to when to escalate are noted to have been documented during the Site Audit, however, there is no evidence to indicate weight monitoring was not occurring as required or that variations in weight were not actioned.

In relation to Consumer F, I have considered that while the Assessment Team suggested an extended care plan was very long, this does not indicate staff did not have access to the information to assist with delivery of care. I have further considered Consumer F’s behaviour management and documentation in my finding for Requirement (3)(b) in this Standard and Requirements (3)(a) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

However, in relation to Consumer I, I find whilst an Allied health recommendation in July 2022 indicated a nutritional supplement should commence, this had not been implemented. The provider has acknowledged this oversight and indicates there was no impact to the consumer as a result. I have also considered this evidence in my finding for Requirement (3)(a) in this Standard.

For the reasons detailed above, I find Requirement (3)(e) in Standard 3 Personal care and clinical care to be Compliant.

### Requirement 3(3)(f) Compliant

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

### 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.*

# STANDARD 4 NON-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 Non-compliant as three of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(b), (3)(c) and (3)(d) in Standard 4 Services and supports for daily living not met. The Assessment Team were not satisfied the service demonstrated:

* services and supports available to promote each consumer’s emotional and psychological well-being are utilised;
* consumers are adequately supported to participate in their community, build social and personal relationships or do things of interest to them; and
* information about consumers’ condition, needs and preferences is effectively communicated within the organisation and with others where responsibility is shared.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(b), (3)(c) and (3)(d). I have provided reasons for my findings in the specific Requirements below.

In relation to all other Requirements in this Standard, consumers and representatives sampled were mostly satisfied that consumers receive safe and effective services to support them to maintain their independence to meet their needs. Staff described services and supports offered to consumers to optimise their independence, health, well-being, and quality of life. Care files sampled for two consumers who had sustained fractures demonstrated improved outcomes with mobility following therapy team input.

There are processes to ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services are initiated. The therapy team respond to referrals from staff to review consumers post falls and hospitalisation and where equipment is required to support consumers’ needs. There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use.

Meals provided are varied and of suitable quality and quantity. Consumers were generally satisfied with the meals, however, indicated meal quality can be inconsistent.

Based on the evidence documented above, I find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Compliant with Requirements (3)(a), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living.

## 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) Non-compliant

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

The Assessment Team were not satisfied the service demonstrated services and supports available to promote each consumer’s emotional and psychological well-being are utilised. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumer C had not been referred to specialist services despite an increase in frequency of documented refusals of care.
* One consumer stated it can feel very lonely at times as so many people have cognitive problems and they have not been supported to find other people in the service they can talk to.
* One consumer stated they found going to the dining room initially very confronting as they were sat at a table with consumers who needed assistance and they were not sure if they were able to ask to move tables, so they had eaten meals in their room instead.
* One consumer was observed to be very upset following an episode of incontinence. Staff were in the process of cleaning up the room, however, were not seen provide any immediate emotional support or reassurance.
* Documentation of incidents involving Consumer P, who was physically assaulted, did not indicate services and supports had been offered or implemented to support the consumer’s emotional and psychological well-being, following the incidents.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* In relation to Consumer C, there is clear evidence refusals were appropriately escalated and followed up to promote their well-being.
* There are systems and processes, including a varied lifestyle program, to meet the needs of consumers.
* Documentation to demonstrate Consumer P participated in regular visits with specialist services and ongoing emotional support was provided.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate each consumer was supported and provided with active and regular services and/or supports to promote psychological or emotional well-being.

In relation to Consumer P, the provider’s response included supporting documentation to demonstrate emotional support was provided following the incidents. However, while progress notes evidence emotional support being provided following one incident, there was no evidence to indicate support had been provided following two incidents which occurred on the same day in March 2022 where the consumer was the victim of a physical assault by another consumer. I have also considered feedback provided by two consumers indicating their emotional and psychological well-being has not been supported, with one consumer indicating they are now having meals in their bedroom as a result.

In relation to Consumer C, I have considered that the evidence presented does not suggest services and supports provided did not promote the consumer’s well-being. Rather, the evidence presented specifically relates to provision of personal care. As such, I have considered the evidence and the provider’s response for Consumer C in my finding for Requirement (3)(a) in Standard 3 Personal care and clinical care.

For the reasons detailed above, I find Requirement (3)(b) in Standard 4 Services and supports for daily living to be Non-compliant.

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

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

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

The Assessment Team were not satisfied the service demonstrated consumers are adequately supported to participate in their community, build social and personal relationships or do things of interest to them. Most sampled consumers and representatives were not satisfied consumers had enough opportunities to do things of interest to them. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two consumers stated they found it lonely at times as so many consumers had cognitive issues. One consumer felt the content of activities was always tailored to the needs of consumers with cognitive issues, which left them feeling isolated. They stated the Lifestyle coordinator was going to assist them with an activity, but had not heard more about this as the coordinator left the service.
* Consumer C’s activity tracker for July 2022 showed of 25 activities, only three related to a coordinated organised activity of which they engaged with two. There was no evaluation of the consumer’s engagement with activities.
* Of 60 listed activities on the activity tracker, Consumer O is recorded as having low/passive or declined the activity in all but seven. The consumer was observed on most occasions to be sitting alone at the same table with minimal engagement.
* Consumer J is no longer able to engage in activities previously set up for them, however, a review of the activity plan has not been conducted or alternative activities provided.
* Consumer G’s activity plan has not been undertaken nor have alternative activities been provided following a change in health.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The service has a lifestyle program consisting of four separate lifestyle calendars tailored to the needs of consumers across each wing. Activities are developed based on consumer need, wants and abilities, taking into consideration past interests and consumer feedback. Consumers can attend activities across any wing.
* A new Lifestyle coordinator commenced the week prior to the Site Audit and had commenced a process of meeting with each consumer to seek feedback.
* Consumer C prefers to stay in their room and not participate in larger group activities and is offered one-to-one support.
* Lifestyle wellness checks for March and June 2022 where Consumer O’s activity preferences were noted and updated and there is clear evidence of the consumer participating in group activities.
* Consumer J engaged in a specific activity for a time but was noted to become frustrated due to a change in condition and loss of interest. Staff identified this and found other related activities which are consistent with a responsive lifestyle program.
* Acknowledge Consumer G’s feedback and have undertaken an open disclosure approach.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate that not all consumers were supported to do things of interest to them.

I acknowledge the provider’s response indicating there are various activities which are tailored to the needs of consumers across each wing. However, in coming to my finding, I have placed weight on feedback provided by most consumers and representatives indicating they were not satisfied consumers had sufficient opportunities to do things of interest to them. Two consumers described the activities as being tailored to the needs of consumers with cognitive deficits which made them feel isolated. I have also considered that appropriate review processes have not been undertaken to determine suitability or effectiveness of the activity program, particularly for Consumers C and O. Documentation for both consumers indicated a lack of engagement in activities they are involved in. As such, I find that the service has not ensured services and supports, specifically the lifestyle program, have been tailored to meet the unique needs of the consumers nor has it provided them with a sense of purpose and identity.

For the reasons detailed above, I find Requirement (3)(c) in Standard 4 Services and supports for daily living, to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated information about consumers’ condition, needs and preferences is effectively communicated within the organisation and with others where responsibility is shared. The Assessment Team’s report provided the following evidence relevant to my finding:

* A representative stated they assumed there was no formal handover of information as staff did not know things about the consumer they had previously told other staff members.
* A representative stated there was no flow of information between staff as some know the consumer and their needs and preferences well and some don’t seem to know anything.
* One consumer stated they know they will get assistance with a shower before breakfast when a specific carer is on shift, if they are not on, they usually have to go to breakfast without showering as staff don’t know their preference.
* An agency staff stated they were given a comprehensive verbal handover, however, they stated nothing was in writing and following the handover they were moved to a different wing. They were unaware there were care plans in consumers’ rooms.
* The therapy team stated it is not always possible to ensure information in relation to daily living supports is passed on consistently to staff as staff change so regularly.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included a range of processes available to share information with staff about consumers’ care and service needs and preferences.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, information about consumers’ condition, needs and preferences was not effectively communicated within the organisation, and with others where responsibility for care was shared. In coming to my finding, I have placed weight on feedback provided by three representatives and/or consumers who indicated consumers do not receive continuity or consistency of services and supports. All three indicated staff do not consistently know consumers’ needs and preferences for care. I have also considered feedback from staff which indicated information relating to consumers’ condition, needs, goals and preferences is not effectively communicated.

For the reasons detailed above, I find Requirement (3)(d) in Standard 4 Services and supports for daily living to be Non-compliant.

### 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 NON-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 Non-compliant as one of the three specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(b) and (3)(c) in Standard 5 Organisation’s service environment not met. The Assessment Team found:

* seven consumers and/or representatives complained about the cleanliness of consumers’ rooms and/or linen; and
* furniture, fittings and equipment were not safe, clean, well maintained and suitable for the consumer.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(b) and Compliant with Requirement (3)(c). I have provided reasons for my finding in the specific Requirements below.

In relation to Requirement (3)(a), the service environment was observed to be welcoming and easy to understand and each consumer’s room was personalised. Signage is available in all areas of the service and is easy to understand and follow.

Based on the evidence documented above, I find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Compliant with Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s living environment.

## 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) Non-compliant

*The service environment:*

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

Consumers and/or representatives were not satisfied with the cleanliness of consumers’ rooms and/or linen. The Assessment Team’s report provided the following evidence relevant to my finding:

* Seven consumers and/or representatives complained about the cleanliness of consumers’ rooms and/or linen. Comments included the floor is dirty; sheets are not regularly clean and/or changed; the bathroom is not clean and there is mould in the sink; and benchtops are sticky.
* A sticky floor in one area of the service was noted on one day of the Site Audit.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The service has a robust cleaning process and monitoring program to ensure cleaning standards are maintained. A sample of documents to support this were included in the response.
* There have been very few complaints relating to cleaning from January to July 2022.
* Acknowledged feedback from representatives relating to cleaning and advised all have confirmed their concerns are recently being addressed and they are seeing improvement in the cleaning service.
* A complaint relating to linen and towels was raised by one representative in January 2022 which was immediately addressed. The representative has never raised or reported issues relating to mould in the bathroom.
* A discussion was held with a representative following the Site Audit relating to issues raised in the Assessment Team’s report. The representative indicated hygiene and cleaning has improved, that is, these were past concerns.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service environment was not clean, well-maintained and comfortable. In coming to my finding, I have placed weight on feedback provided by seven representatives who were not satisfied with the cleanliness of consumers’ rooms and/or linen. Feedback provided indicates the service environment, specifically consumer rooms, is not consistently maintained to ensure consumers feel relaxed, comfortable and at home.

For the reasons detailed above, I find Requirement (3)(b) in Standard 5 Organisation’s living environment to be Non-compliant.

### Requirement 5(3)(c) Compliant

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

The Assessment Team were not satisfied the service demonstrated furniture, fittings and equipment were safe, clean, well maintained and suitable for the consumer. The Assessment Team’s report provided the following evidence relevant to my finding:

* A progress note in June 2022 indicates staff washed Consumer O’s wheelchair as bugs were found crawling on the seat.
* Representatives stated a consumer’s bathroom door was jammed shut for two to three days and the consumer’s dentures were locked in the bathroom. The representative fixed the issue. Management indicated they were only informed of the jammed door on the weekend and the representative accessed the bathroom before maintenance could arrive on site. Arrangements had been made for the consumer to access a different bathroom.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* In response to the bugs, staff immediately actioned this by cleaning the wheelchair, in line with policy and process. There is no evidence to suggest that the bugs were a result of cleaning failures.
* The service was informed of the issue on the weekend; the issue was immediately escalated to management and relevant corrective actions. An apology and open disclosure process occurred at the time in relation to the consumer not being able to access their dentures.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. In coming to my finding, I have considered the evidence presented does not demonstrate systemic issues with the service’s processes related to ensuring furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. On review of supporting documentation included in the provider’s response, I have considered both issues highlighted were isolated incidents which were reported and appropriately actioned in a timely manner.

For the reasons detailed above, I find Requirement (3)(c) in Standard 5 Organisation’s living environment to be Compliant.

# 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 two of the four specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(c) and (3)(d) in this Standard not met. The Assessment Team were not satisfied the service demonstrated:

* appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong; and
* sustained improvements that were sustained or consumers’ concerns are addressed.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(c) and (3)(d). I have provided reasons for my findings in the specific Requirements below.

In relation to Requirements (3)(a) and (3)(b) in this Standard, consumers and representatives confirmed they are aware of how to make complaints and provide feedback. However, they indicated that due to the lack of response to feedback and complaints, they did not feel encouraged to lodge complaints. Management has an open door policy enabling consumers and representatives to provide feedback at any time. Consumers are also assisted to complete electronic survey forms which include a variety of questions in line with the consumer statements in the Quality Standards. This method enables feedback to be gathered from consumers with vision impairments or those who cannot or do not fill in feedback forms.

Consumers are provided with information about internal and external feedback and complaints mechanisms on entry. Feedback forms and external complaints and advocacy information was also observed on display and secure return boxes were observed and accessible.

Based on the Assessment Team’s report, I find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Compliant with Requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints.

**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) Non-compliant**

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

The Assessment Team were not satisfied appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. The Assessment Team’s report provided the following evidence relevant to my finding:

* Thirteen consumers and representatives were not satisfied with feedback processes or feel an open disclosure approach is used to inform them of outcomes.
* Representatives indicated they had been raising issues over the past 10 months relating to Consumer C’s personal care and have not seen an improvement. As a last resort, they raised their issues with head office May 2022 and are still waiting for a response from the service. Additionally, representatives indicated they had not been informed the consumer had developed a pressure injury.
* An open disclosure process was not demonstrated in response to complaints made to the Commission in January and February 2022 by Consumer F’s family. Information about the investigation, outcomes, or changes implemented had not been received.
* Consumer L’s representative sent many emails but was not informed of any outcomes other than it will be looked into.

I have also considered information in Standard 1 Consumer dignity and choice Requirement (3)(e) and Standard 3 Personal care and clinical care Requirement (3)(a), and the provider’s response, specifically:

* A representative stated they never received satisfactory information in relation to the outcome of an investigation into an incident in 2021 involving Consumer B.
* An incident form indicated Consumer D had been administered a vaccination without consent being obtained.
* Consumer J’s representative was not aware of any recent incidents relating to missed medications in May to August 2022.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* Correspondence demonstrating management contacted Consumer C’s representative on the day the complaint was received.
* Clinical documentation dated December 2021 to February 2022 to demonstrate communication and correspondence with Consumer F’s representatives.
* The service does not have any evidence of emails from Consumer L’s representative.
* Management met with Consumer B’s representative to discuss the incident. It is acknowledged there was a missed opportunity for ongoing communication with the representatives about the review that occurred.
* Consumer D’s vaccination incident was reported once identified, with an open disclosure approach initiated and appropriate steps implemented to prevent recurrence, including new processes relating to consent.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate a best practice system for managing and responding to complaints.

In coming to my finding, I have considered feedback provided by 13 consumers and representatives who were not satisfied with feedback processes and did not feel an open disclosure approach was applied to inform them of outcomes. While the provider’s response indicated they had communicated with complainants in response to feedback raised, feedback provided by consumers and/or representatives indicated they are not satisfied with the processes or outcomes.

Where things have gone wrong, services are expected to inform the consumer and/or representative, apologise, explain what happened and what actions will be taken to prevent reoccurrence. In coming to my finding, I have considered that information provided relating to Consumers B, C and J indicates the service did not apply open disclosure processes in response to incidents. In relation to Consumer D, the provider’s response included an incident report indicating the consumer’s next of kin was notified when the incident when it was identified, 25 days later, however, the incident form does not demonstrate an open disclosure process was applied. Further discussions relating to the incident were noted to have occurred 27 days after the incident was identified.

In relation to Consumer L, while the provider indicates there is no evidence of emails being received, evidence presented in Standard 2 Ongoing assessment and planning with consumers Requirement (3)(d) suggest emails sent by representatives have gone unanswered. I would encourage the service to review their processes as it relates to email correspondence from representatives.

For the reasons detailed above, I find Requirement (3)(c) in Standard 6 Feedback and complaints to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated sustained improvements that were sustained or consumers’ concerns are addressed. The Assessment Team’s report provided the following evidence relevant to my finding:

* Seven of seven consumers and representatives felt the service had not made any improvements that were sustained or that their ongoing issues had been addressed. Ongoing issues related to cleaning, linen, personal care and staffing levels.
* Verbal and email feedback was not included in the trended data in feedback files from January to June 2022.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The service made improvements in response to one representative’s feedback with evidence of communication, and regrets the representative remained dissatisfied.
* It is unreasonable to assert that all email and verbal feedback is to be captured in the feedback system. With the implementation of an electronic feedback system in September 2022, it will be easier for staff to enter, report and trend feedback data.
* Workforce has been increased, noting the service is close to meeting the care minute requirement that is not due for another year.
* The gap in service and cleaning raised by one representative was addressed with improvements made.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, feedback and complaints were not being used to improve the quality of care and services.

In coming to my finding, I have placed weight on information provided by consumers and representatives indicating they felt the service had not made any improvements that were sustained or that their ongoing issues had been addressed to improve care and service delivery. In relation to feedback received verbally and through email correspondence, I have considered that by not including this feedback in trended data, this has not provided the service an opportunity to identify emerging trends or implement improvement initiatives in response, which has the potential to result in ongoing issues. As such, I find this has not ensured that all feedback is considered or used to identify trends or enabled improvements to the quality of care and services to be identified and implemented.

For the reasons detailed above, I find Requirement (3)(d) in Standard 6 Feedback and complaints to be Non-compliant.

# 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 five of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended all five Requirements in Standard 7 Human resources not met. The Assessment Team were not satisfied the service demonstrated:

* the workforce is planned to enable the right mix and number of staff to ensure the delivery and management of safe and quality care and services;
* all workforce interactions are kind, caring and respectful of each consumer’s identity, culture and diversity;
* all members of the workforce have the knowledge to effectively perform their role or provide care within their scope of practice;
* the workforce, once recruited, receives sufficient training on an ongoing basis and is equipped and supported to deliver the outcomes of these Standards; and
* ongoing monitoring of the performance of staff is consistently undertaken.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Non-compliant with all five Requirements in Standard 7 Human resources. I have provided reasons for my findings in the specific Requirements below.

## 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.*

The Assessment Team were not satisfied the service demonstrated the workforce is planned to enable the right mix and number of staff to ensure the delivery and management of safe and quality care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* All consumers and representatives interviewed did not consider the number and mix of staff sufficient to ensure consumers’ personal care, clinical care, emotional and/or social supports were consistently met, impacting consumers’ dignity and physical and emotional well-being.
* Specific impacts attributed to insufficient staff included personal care not being attended; delay in medication administration; continence aids not being changed in line with care plans; and consumers being left by themselves during the day and night. Use of agency staff, specifically in the memory support area was raised, resulting in a lack of consistency of care as well as staff turning call bells off without attending to consumers’ needs.
* Regarding the current clinical team structure, management, consumer and representative feedback, observations and documents reviewed indicated the clinical management team were, at the time of the Site Audit, under resourced, not yet across understanding consumer care needs and were not able to effectively train and monitor staff performance.
* All staff interviewed said they often work one to two care staff short, often with less experienced agency staff who do not know consumers’ needs and preferences, and students, who rather than being trained and mentored, are used to fill gaps in the roster. Impacts, including to continence management; afternoon tea not being provided; consumers receiving washes instead of showers; and creams not being applied for consumers’ skin were described as being attributed to insufficient staff.
* Allocation sheets showed a high reliance on agency usage.

The provider strongly rejected the Assessment Team’s claims and their use to infer deficiencies in workforce planning, number and mix to deliver and manage safe and quality care and services. The provider’s response included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The service’s performance (actual data) against the care minutes requirements, yet to be implemented, including that the total care minutes are six minutes short of the target for October 2023.
* Acknowledge feedback from consumers and representatives.
* Refute the service has an under-resourced clinical team and that it has a high turnover of clinical leadership.
* It is factually incorrect that the secure dementia-specific areas were short staffed or they were frequently short the allocated care staff.
* Students are not counted in staffing numbers or used to fill unfilled shifts.
* It is not correct that areas of the service were often working one or two care staff short. For the month of July 2022, only 2.5% of shifts were unfilled.
* Over the nine day period sampled by the Assessment Team, 104 of 437 shifts or 23.8% were filled by agency.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not effectively demonstrate there were adequate numbers and mix of staff to deliver safe and quality care and services.

In coming to my finding, I have placed weight on feedback provided by all consumers and representatives sampled indicating insufficient staffing numbers to provide quality care and services which has resulted in impacts for consumers. I have also considered feedback provided by all sampled staff indicating staffing levels are not sufficient to support the effective delivery of care and services to consumers and the resulting impacts to consumers described by staff. Furthermore, I find that the service’s regular use of agency staff, who are not familiar with the specific needs of consumers, has not supported continuity of care and services or enabled relationships of trust to be built with consumers.

In relation to clinical leadership and oversight, I have considered this evidence and the provider’s response in my findings for Requirements (3)(c) and (3)(e) in this Standard.

For the reasons detailed above, I find Requirement (3)(a) in Standard 7 Human resources to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated all workforce interactions are kind, caring and respectful of each consumer’s identity, culture and diversity. The Assessment Team’s report provided the following evidence relevant to my finding:

* Over 20 consumers and representatives said staff were often rushed as they are working short, with some saying staff are task focused rather than providing kind, caring and respectful person-centred care.
* Some staff interactions observed were task orientated and did not afford each consumer with kind, respectful and compassionate care.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* In relation to one named consumer, an apology has been provided, however, the incident seems to be an inadvertent mistake and is not evidence of a failure against the Requirement.
* Examples provided by the Assessment Team are generic in nature and do not provide sufficient detail to allow proper investigation and a right of reply.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not effectively demonstrate workforce interactions are kind, caring and respectful of each consumer’s identity, culture and diversity.

In coming to my finding, I have placed weight on feedback provided by the vast majority of consumers and representatives indicating that due to staff shortages, care provided to consumers is rushed resulting in staff being task focused rather than providing care in a way that was consistently person-centred, kind, caring and respectful. This was supported by observations made by the Assessment Team. Impacts to some consumers were described as a consumer being very upset and feeling uncared for and a consumer crying and visibly distraught. I find that such interactions have the potential to impact the outcomes of consumers’ care and services, including their safety, health and well-being.

For the reasons detailed above, I find Requirement (3)(b) in Standard 7 Human resources to be Non-compliant.

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

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

The Assessment Team were not satisfied all members of the workforce have the knowledge to effectively perform their roles or provide care within their scope of practice. The Assessment Team’s report provided the following evidence relevant to my finding:

* At least 20 consumers and representatives were not confident all staff, including agency staff and students, were competent and had the knowledge to provide safe and quality care.
* Deficits in the current clinical leadership structure and high clinical staff turnover have impacted the supervision structure usually in place to monitor staff competency.
* Care staff are directly monitored by registered staff, some of whom are new and junior nurses. Registered staff are monitored by the Clinical team leader who commenced three weeks prior to the Site Audit, and is still being inducted. The Clinical team leaders are supported by the Clinical care manager, a position that has been vacant for approximately six weeks. Management reported this position has had four to six incumbents over a 12-month period.
* The therapy team stated frequent changes in staff and regular use of agency staff impacts their ability to set up therapy programs that can be continued by care staff when the therapy team are not on site.

I have also considered information in Requirement (3)(d) in this Standard and the provider’s response, specifically:

* Three care staff confirmed agency staff and students work at least partially unsupervised and are not fully able to be supported by regular staff.
* Two students said they felt compelled to complete tasks beyond their skill and capacity, including transferring consumers using a hoist, showering consumers alone and assisting consumers with changed behaviours.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* It is not unreasonable for a new Clinical team leader to still be in the induction phase after three weeks. Having a workforce mix with some registered staff who are new and junior nurses is not a deficiency.
* The service has sourced appropriate numbers of care staff each day and made arrangements for appropriate supervision.
* Reviewed issue raised by the therapy team and are satisfied required actions are in place.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the workforce was not sufficiently competent or had the qualifications and knowledge to effectively perform their roles.

In coming to my finding, I have placed weight on feedback provided by the majority of consumers and representatives who indicated they lacked confidence in the competency of staff to provide safe and quality care to consumers. Feedback from staff indicated agency staff and students work at least partially unsupervised and two students indicated they felt compelled to complete tasks, including provision of consumers’ care and services, beyond their skill and capacity. Furthermore, I have considered feedback from therapy staff indicating due to frequent changes in staff and regular use of agency staff, consumers’ therapy programs are impacted as the competence and ability of the care staff who would be undertaking these programs cannot be ascertained. As such, I find the current clinical leadership structure has not been effective in monitoring the workforce to ensure staff are sufficiently competent and are working within their scope of practice.

I have also considered outcomes for consumers highlighted in Standard 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 Requirements (3)(a) and (3)(b), which have been found Non-compliant, demonstrate consumers have not been provided care that is best practice, tailored to their needs or optimised their health and well-being or that high impact or high prevalence risks have been effectively managed. Deficits have been identified in provision of personal care and management of skin integrity, nutrition and hydration, wounds, medications, swallowing risks and falls. Furthermore, I have considered that these Requirements were found Non-compliant following an Assessment Contact in November 2021 where similar issues relating to management of continence, medications, skin integrity and falls were identified.

For the reasons detailed above, I find Requirement (3)(c) in Standard 7 Human resources to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated the workforce, once recruited, receives sufficient training on an ongoing basis and is equipped and supported to deliver the outcomes of these Standards. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumers and representatives consistently said they are not confident agency staff and students, who are regularly providing care, are sufficiently trained and supported to provide quality care to consumers.
* Regular and agency staff said staff do their best to train agency staff, however, they are unable to spend adequate time orientating. In addition, there were not consistent, effective tools which were readily available, to assist them to understand the needs and preferences of consumers or to orientate new staff, agency staff and students easily and quickly.
* Three care staff said as they were often working short, buddy shifts were often not used as intended and confirmed agency staff and students work at least partially unsupervised and are not fully able to be supported by regular staff. Some staff said they worked unsupervised during their buddy shifts as the service was understaffed.
* Two students did not feel supported to understand the care requirements of consumers with cognitive impairment and did not receive adequate training on site before they commenced providing direct care to consumers. The students said they felt compelled to complete tasks beyond their skill and capacity.
* Senior clinical staff indicated a significant increase in medication incidents from May to June 2022 was in part due to agency staff errors and further training and support was required.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* Implemented an extension of the handover period and printing of handover sheets.
* Highlighted a range of processes to demonstrate how information relating to consumer’s care and service needs are communicated with staff.
* Students are not counted in staffing numbers or used to fill unfilled shifts. The three students on site at the time of the Site Audit were allocated to an individual staff on a buddy shift arrangement. The students are not expected to understand the care requirements of consumers as they are always supervised and buddied.
* Medication errors were identified by the Registered nurse and appropriate corrective actions taken.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not adequately demonstrate processes to ensure the workforce is trained, equipped and supported to deliver the outcomes required by these Standards.

In coming to my finding, I have placed weight on feedback from consumers and representatives who indicated they are not confident agency staff and students, who regularly provide care, are sufficiently trained and supported to provide quality care to consumers. Feedback from staff indicated students have not been consistently supervised until they have the competence to carry out their role. Staff indicated they work unsupervised during buddy shifts and other staff stated buddy shifts are often not used as intended. I acknowledge the provider’s response indicating students are not counted in staffing numbers or used to fill unfilled shifts, however, feedback from some staff indicated they work unsupervised during their buddy shifts as the service is understaffed. I have also considered feedback two students who did not feel supported to understand the care requirements of consumers with cognitive impairment and/or received adequate training on site before they commenced providing direct care to consumers.

In coming to my finding, I have also considered Standard 3 Personal care and clinical care Requirements (3)(a) and (3)(b), which were found Non-compliant following an Assessment Contact in November 2021 have again been found Non-compliant indicating the workforce have not received the ongoing training, professional development and supervision to effectively undertake their roles and responsibilities.

For the reasons detailed above, I find Requirement (3)(d) in Standard 7 Human resources to be Non-compliant.

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

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

The Assessment Team were not satisfied ongoing monitoring of staff performance is consistently undertaken. The Assessment Team’s report provided the following evidence relevant to my finding:

* Deficits in the current clinical leadership structure and clinical staff turnover have impacted on the supervision structure usually in place to monitor staff performance.
* Senior clinical staff did not monitor staff performance to ensure they were adhering to Consumer E’s risk assessment plan relating self-administration of medication.
* Agency staff performance was not monitored following an increase in medication incidents which clinical management attributed to agency staff performance.
* Staff performance is not being monitored in relation to cleaning of consumers’ rooms and bedlinen.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider’s response included, but was not limited to:

* The service has a robust clinical leadership structure in place.
* Acknowledge and accept identified improvements relating to the isolated error regarding Consumer E’s medication and changes in response have been implemented.
* At all times, agency staff, responsible for administration of medications, are supervised by the Registered nurse. Medication incidents noted were largely identified by the Registered nurse and corrective action taken.
* The service has a robust cleaning process and monitoring program to ensure cleaning standards are maintained.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, ongoing monitoring of the performance of each member of the workforce was consistently undertaken.

In coming to my finding, I have considered that while the service has a performance management system in place to review and monitor staff performance, deficits identified by the Assessment Team across all eight Quality Standards have not been identified. I have also considered that while a clinical leadership structure is in place, this has not effectively ensured the performance of the workforce is monitored and further training and support opportunities identified. As such, I find the service’s ongoing monitoring of the workforce’s duties, responsibilities and performance has not been effective.

For the reasons detailed above, I find Requirement (3)(e) in Standard 7 Human resources to be Non-compliant.

# 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 five of the five specific Requirements have been assessed as Non-compliant.

Requirement (3)(d) was found Non-compliant following an Assessment Contact undertaken on 24 November 2021, where it was found the service did not demonstrate and effective risk management system, specifically in relation to management of high impact or high prevalence risks associated with consumer care. The Assessment Team found the organisation/service had not successfully implemented improvements to address the previous finding of non-compliance and these deficits remain.

At the Site Audit, the Assessment Team recommended all five Requirements in Standard 8 Organisational governance not met. The Assessment Team were not satisfied the service demonstrated:

* consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement;
* the governing body promotes a culture of safe, inclusive quality care and services and are accountable for the delivery;
* effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints;
* effective risk management systems and practices; and
* an effective clinical governance framework relating to open disclosure and clinical leadership.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find Regis Aged Care Pty Ltd, in relation to Regis Port Coogee, to be Non-compliant with all Requirements in Standard 8 Organisation governance. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 8 Requirements

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

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

The Assessment Team were not satisfied the service demonstrated consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumers and representatives did consider the organisation supports and encourages their involvement in improving care and services, particularly when they had provided feedback about care and services. They did not feel providing their views made a difference to how their relative was cared for or resulted in change to the wider service community.
* Over 19 consumers and representatives said they had told service management about concerns relating to a range of areas. All indicated their feedback did not result in significant improvements either to their relative or other consumers and felt meaningful engagement had not occurred.
* Five representatives did not feel the format of the resident and representatives’ meetings was effective in harnessing their engagement and although management identified care plan reviews as a method of engagement, four representatives said they were not involved in this process.

The provider generally did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. The provider did acknowledge that stronger consumer engagement was required given the negative feedback, even when responses had been provided and improvements made. In coming to a finding of compliance for this Requirement, I have considered the provider’s response, specifically Attachment 4 Standard 8 Governance, pages 3 to 5 which included commentary addressing the Assessment Team’s report.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the organisation’s processes did not ensure consumers are engaged in development, delivery and evaluation of care and services and are supported in that engagement. I have considered that while there are various avenues for consumers to engage in development, delivery and evaluation of care and services, feedback provided by consumers and representatives indicate these avenues are not consistently effective or that feedback provided through these avenues has resulted in improving the overall quality of care and services consumers receive. Over half of the consumers and representatives sampled did not feel feedback they had provided resulted in significant improvements either to their relative or other consumers and felt meaningful engagement had not occurred. As such, I find this has not ensured consumers’ experience and quality of care and services has been considered in the development, delivery and evaluation of care and services.

For the reasons detailed above, I find Requirement (3)(a) in Standard 8 Organisational governance to be Non-compliant.

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

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

The Assessment Team were not satisfied the service demonstrated the governing body promotes a culture of safe, inclusive quality care and services and are accountable for the delivery. The Assessment Team’s report provided the following evidence relevant to my finding:

* Despite having a history of non-compliance, the organisation has not ensured the service remains compliant.
* Nine consumers/representatives have made numerous complaints with three now dealing directly with head office. There are also five external complaints which are currently open.
* The organisation has not ensured the service had effective clinical overview and guidance for the last six weeks while they were in the process of recruiting a Clinical care manager. The organisation sent in full time clinical assistance two to three weeks prior to the Site Audit, despite there being a sharp increase in serious medication errors in June 2022, that are not resolving with the interventions attempted.
* Clinical team lead positions have been vacant with one of the two positions being filled approximately three weeks prior to the Site Audit.
* The service has a high usage of agency staff and are attempting to recruit staff, yet the service was not able to demonstrate the organisation has assisted with staff retention to ensure there is a consistency of staff who can provide quality care. Whilst it is acknowledged there are difficulties with staffing in the Aged Care sector, it was not demonstrated the Board has taken action to address this issue.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. In coming to a finding of compliance for this Requirement, I have considered the provider’s response, specifically Attachment 4 Standard 8 Governance, pages 5 to 12 which included commentary addressing the Assessment Team’s reports, and supporting documentation in attachments 10 to 15.

The provider’s response indicated the Board was closely involved in improvements at the service following previous findings of non-compliance; there is a three year strategic plan demonstrating the organisation’s focus on workforce and consumer care; the Board has a strong clinical governance reporting framework; and examples of actions taken by the Board to improve quality and safety for consumers were outlined. Additionally, the response included a timeline of the Clinical Care manager role demonstrating the role had been filled at all times by different staff members; asserted the service has an ongoing recruitment strategy for all care roles; and a People and renumeration committee has been constituted by the Board which have considered matters relating to turnover data, agency use and workforce and recruitment strategy.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the organisation did not effectively demonstrate the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. In coming to my finding, I have placed weight on feedback provided by consumers and representatives across the eight Quality Standards indicating dissatisfaction with care and services across a range of areas, including assessment, planning and review processes; provision of personal and clinical care; services and supports for daily living; cleanliness of the environment; feedback and complaints processes; and sufficiency, competence and knowledge of staff. I have also considered findings of non-compliance at the Site Audit relating to 24 Requirements across alleight Quality Standards. As such, I find this does not demonstrate that the governing body is aware of consumers and representatives expectations relating to safe and quality care and services or that the governing body understands or endeavours to set priorities to improve the performance of the service against the Quality Standards.

For the reasons detailed above, I find Requirement (3)(b) in Standard 8 Organisational governance to be Non-compliant.

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

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

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

While systems relating to financial governance were found to be effective, the Assessment Team were not satisfied effective organisation wide governance systems were demonstrated relating to information management, continuous improvement, workforce governance, regulatory compliance or feedback and complaints. The Assessment Team’s report provided the following evidence relevant to my finding:

* In relation to information management, nine regular staff, agency staff and students did not consider information easily and readily available to enable them to know consumers’ needs, preferences and requirements for care, particularly in the context of staff shortages and a high use of agency staff. Care plans that are easily read, succinct, and enables delivery of appropriate care are not provided. Staff consistently reported there were not effective tools which were readily available, to assist them to understand consumers’ needs and preferences when working short staffed and with agency staff and students to guide, train and monitor.
* A plan for continuous improvement was provided in January 2022 relating to addressing findings of non-compliance identified in January and September 2021. While the plan outlined planned actions to address the deficits these have not been effective and/or sustained. The experiences of consumers and representatives, including issues related to staffing, care provision, cleaning and the feedback and complaints system have not been effectively addressed or an adequate plan for continuous improvement developed. Consumers and representatives sampled remain dissatisfied.
* In relation to workforce governance, challenges in ensuring adequate numbers and the right mix and skill level of staff are being experienced and current staffing levels are directly impacting on consumers’ physical, social and emotional well-being. Management are aware of staffing difficulties and are trying to resolve this, however, the service remains understaffed, has a high turnover of clinical staff, a high reliance on agency staff, and effective solutions to resolve the impact of staff shortages on consumers have not been implemented.
* Deficits in clinical leadership over the past 12 months and significantly in the previous two to three months, has impacted directly on clinical oversight, monitoring of staff performance and staff education, resulting in deficits in the delivery of quality care and services for consumers.
* Effective governance systems in relation to the regulatory requirement to obtain informed consent for the use of chemical restrictive practice was not fully demonstrated, specifically in relation to Consumer A.
* Feedback and complaints mechanisms were not effective in capturing all feedback, the systemic nature of the complaints were not fully identified by the service, and suitable actions to resolve not only individual complaints but address systemic issues, were not effective.
* Consumers and representatives stated deficits in the feedback and complaints system resulted in a lack of confidence in the service’s capacity to fully resolve issues and some representatives had sought assistance via external avenues. Five consumers and representatives said they had not received acknowledgement of complaints they had made and/or any information about the outcomes.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. In coming to a finding of compliance for this Requirement, I have considered the provider’s response, specifically Attachment 4 Standard 8 Governance, pages 12 to 20 which included commentary addressing the Assessment Team’s report, and supporting documentation in attachments 16 and 17. Supporting documentation relating to Consumers F, H, A and L and Requirement (3)(a) in Standard 7 Human resources was also considered.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, while effective organisation wide governance systems were demonstrated relating to information management, financial governance and regulatory compliance, governance systems relating to continuous improvement, workforce governance and feedback and complaints were not effective to ensure accountability and action at all levels of the organisation.

In relation to information management, I find staff have access to information through various avenues to assist in provision of care and services to consumers. I consider that the feedback from staff in relation to information systems relates to sufficiency and mix of staff and a lack of time to access the information required. I acknowledge the provider’s response which demonstrates improvement initiatives are in progress to enhance information management systems and processes, including a planned upgrade to the electronic care management system and improvements relating to the handover process have been implemented.

In relation to continuous improvement, I have considered that the organisation’s systems and processes have not been effective in assessing, monitoring and improving the quality of care and services. I have considered evidence highlighted in Standard 6 Feedback and complaints Requirement (3)(d) indicating consumers and representatives felt the service had not made any improvements that were sustained or that their ongoing issues had been addressed to improve care and service delivery. Additionally, I have considered the findings of non-compliance in relation to 24Requirements across all eight Quality Standards indicates deficiencies with the governance processes associated with continuous improvement.

In relation to workforce governance, I consider the findings of non-compliance in all five Requirements in Standard 7 Human resources indicates deficiencies with workforce governance systems and practices. I find the organisation’s processes have not ensured the workforce is sufficient, competent, trained or sufficiently supported to deliver safe and quality care and services to consumers.

In relation to regulatory compliance, the evidence presented does not indicate a systemic issue relating to this aspect of the Requirement. The evidence relating to Consumer A has been considered in my finding for Requirement (3)(c) in Standard 1 Consumer dignity and choice.

In relation to feedback and complaints, while the provider’s response indicates complaints raised have been addressed and improvements made, I have considered that feedback from most consumers and representatives indicates that despite providing feedback relating to staffing, personal and clinical care and cleaning, these concerns remain ongoing and have not been resolved using feedback mechanisms available. I have also considered that while the provider asserts it is unreasonable that all email and verbal feedback is captured, I find this has not ensured that all complaints are identified or analysed to assist to identify trends and opportunities for improvement. Furthermore, I consider the findings of non-compliance in relation to Standard 6 Feedback and complaints Requirements (3)(c) and (3)(d) indicates deficiencies with the governance processes associated with feedback and complaints and that key deficits in care and services described by consumers and representatives and identified by the Assessment Team had not been addressed to the complainants satisfaction.

For the reasons detailed above, I find Requirement (3)(c) in Standard 8 Organisational governance to be Non-compliant.

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

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

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

Requirement (3)(d) was found Non-compliant following an Assessment Contact undertaken on 24 November 2021, where it was found the service did not demonstrate and effective risk management system, specifically in relation to management of high impact or high prevalence risks associated with consumer care. The Assessment Team found the organisation/service had not successfully implemented improvements to address the previous finding of non-compliance and these deficits remain.

At the Site Audit, the Assessment Team were not satisfied the service demonstrated effective risk management systems and practices. The Assessment Team’s report provided the following evidence relevant to my finding:

* In relation to managing high impact or high prevalence risks, clinical indicator reports for June 2022 showed a significant increase in medication incidents from May 2022. Corrective actions included the Clinical care manager to check weekly medication signing sheets, however, the service does not currently have a Clinical care manager.
* Ongoing medication incidents were found not to be recorded, consumers self-administering medications were not monitored in line with assessments and evidence of missed medication impacting consumers.
* In relation to managing and preventing incidents, four incidents were noted to have not been recorded in the electronic care management system, investigations into incidents were not consistently undertaken nor interventions implemented. Staff had not identified one incident relating to Consumer F as reportable under the Serious Incident Response Scheme (SIRS) and another incident reported under SIRS for Consumer E had not resulted risk assessments being conducted nor implementation of appropriate strategies to ensure the consumer’s safety and well-being.
* In relation to identifying and responding to abuse and neglect of consumers, three incidents were reported through SIRS in March 2022 following incidents of unreasonable use of force by Consumer K towards Consumer P. Risk assessments were not completed nor appropriate strategies implemented to ensure Consumer P’s well-being and safety. One of the incidents was not managed in line with the organisation’s incident management and reporting policy.
* In relation to supporting consumers to live the best life they can, the service was not able to demonstrate consumers were supported to make choices where an element of risk was identified, specifically in relation to medication management for Consumer E.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. In coming to a finding of compliance for this Requirement, I have considered the provider’s response, specifically Attachment 4 Standard 8 Governance, pages 20 to 26 which included commentary addressing the Assessment Team’s report, and supporting documentation in attachment 18. Supporting documentation relating to Consumers J, K, P and E was also considered.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation did not demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers or managing and preventing incidents.

In coming to my finding, I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks, specifically in relation to management of wounds, medication, swallowing risks and falls as highlighted in Standard 3 Personal and clinical care Requirement (3)(b). I have also considered that the organisation’s own monitoring processes have not identified deficits identified by the Assessment Team relating to management of high impact or high prevalence risks to consumers’ care. In relation to increased medication incidents in June 2022, I acknowledge the provider’s response indicating all incidents have been reviewed and investigated.

In relation to identifying and responding to abuse and neglect, I have considered that following the incidents, actions were initiated in response and a family meeting was initiated. While the provider’s response indicates no further incidents were recorded following the last incident, I have considered that appropriate safeguards were not initiated following the incidents, specifically for Consumer P. Care plans for both consumers did not demonstrate review or updates to management strategies for the known behaviours had occurred. However, I do not consider that the evidence presented indicates systemic deficits with risk management systems and practices as they relate to identifying and responding to abuse and neglect of consumers.

I have also considered staff have not demonstrated an understanding and application of incident reporting and escalation processes. Not all consumer incidents had been documented, escalated or reported. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement or risks to consumers’ health and well-being are minimised and/or eliminated. I have noted the provider’s response relating to an incident involving Consumer L where a medication was found on the consumer’s bedside table. The provider asserts as a result of a General practitioner review, the medication was stopped, no incident occurred, therefore, no incident report was required to be completed. I find this incident suggests a gap in staff knowledge and practice relating to medication administration. By not undertaking an incident reporting process for these incidents, the prevalence of like incidents or staff training requirements cannot be identified.

In relation to an incident in May 2022 involving Consumer E, I accept the provider’s response indicating this was an isolated incident and find appropriate follow up, including incident reporting, occurred post the incident. Additionally, in relation to Consumer F, the incident occurred during the Site Audit and I accept the provider’s response.

In relation to supporting consumers to live the best life they can, the evidence presented does not indicate a systemic issue as it relates to this aspect of the Requirement. Rather, the evidence presented relates to implementation of risk management strategies for one consumer, Consumer E. I have also considered Requirement (3)(d) in Standard 1 Consumer dignity and choice was recommended met by the Assessment Team. Evidence presented in Standard 1(3)(d) demonstrates there are risk management systems and processes to support consumers to live the best life they can. This includes completion of risk assessment forms in consultation with consumers and representatives identifying the risk, contributing factors and mitigation strategies. Additionally, a risk register is maintained. Evidence relating to the Consumer E has been considered in my finding for Requirement (3)(b) in Standard 3 Personal care and clinical care.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance to be Non-compliant.

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

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

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

The organisation demonstrated an effective clinical governance framework relating to antimicrobial stewardship and minimising use of restraint. However, the Assessment Team were not satisfied the service demonstrated an effective clinical governance framework, specifically in relation to open disclosure and clinical leadership. The Assessment Team’s report provided the following evidence relevant to my finding:

* In relation to clinical leadership, improvements relating to clinical, best practice care and management of high impact or high prevalence risks identified following performance assessments in January and September 2021, have not been implemented and/or evaluated for effectiveness.
* The clinical management team has experienced challenges over the past 12 months and more significantly in the past two to three months. In addition, one Clinical team lead has been employed (for a period of three weeks) to provide clinical oversight and leadership for the 126 consumers at the service.
* Clinical leadership has not been robust for a period of time as evidenced by previous non-compliance in Standard 3 Requirements (3)(a) and (3)(b) and Standard 8 Requirement (3)(d) following an Assessment Contact in January 2022.
* In relation to open disclosure, multiple examples were found where the minimum open disclosure requirements, as outlined in the in the service’s policy, were not adhered.
* In relation to minimising the use of restraint, Consumer O’s representative indicated they had found the consumer, on more than one occasion, alone at a table, facing a wall rather than other consumers. A staff member said the consumer is at times moved to a quiet activity room on to manage changed behaviours. The consumer is not able to mobilise independently. Senior clinical staff said the service does not consider this practice to be seclusion.

The provider did not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team, as well as supporting documentation. In coming to a finding of compliance for this Requirement, I have considered the provider’s response, specifically Attachment 4 Standard 8 Governance, pages 26 to 30 which included commentary addressing the Assessment Team’s report, and supporting documentation in attachments 19 to 23. Supporting documentation relating to Consumer A and Requirement (3)(a) in Standard 7 Human resources was also considered.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation did not demonstrate effective open disclosure processes or clinical leadership.

In coming to my finding, I have considered that while a clinical leadership structure is in place this has not effectively ensured the performance of the workforce is monitored and quality care and service delivery to consumers is maintained, good clinical results achieved and improvement opportunities identified. I have also considered the findings of non-compliance in two of the seven Requirements in Standard 3 Personal care and clinical care, which have been Non-compliant since an Assessment Contact undertaken in November 2021, indicating the organisation’s clinical governance framework is not effective, with deficits highlighted not being identified by the service’s or organisation’s own monitoring processes.

In relation to open disclosure, I have considered the organisation’s systems have not supported effective communication relating to incidents involving consumers or that actions taken to prevent like incidents occurring have been effectively explained to consumers and/or representatives. The provider’s response included supporting documentation to demonstrate open disclosure had been applied in relation to Consumers J and G named in the Assessment Team’s report, the documentation supplied did not align with the all the dates medication incidents occurred or when a wound had deteriorated and, therefore, did not demonstrate open disclosure principles had been implemented. I have also considered evidence in Standard 6 Feedback and complaints Requirement (3)(c), including feedback provided by representatives, indicating an open disclosure process has not been consistently applied in response to concerns raised.

In relation to Consumer O, aside from one staff member indicating the consumer is moved to a quiet activity room to manage changed behaviours, there was no other evidence presented to indicate this strategy is initiated or that it is initiated on a regular basis. As such, I have considered the practices described do not constitute seclusion.

For the reasons detailed above, I find Requirement (3)(e) in Standard 8 Organisational governance to be Non-compliant.

# 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)(c)**

* Ensure staff have the skills and knowledge to provide care and services to consumers in a way which ensures they are treated with dignity and respect and values their culture and diversity.
* Ensure staff interactions with consumers are monitored to ensure kind, caring and respectful interactions are maintained at all times.
* Ensure consumers are supported to exercise choice and independence, including in relation to making and communicating decisions about the way care and services are delivered.

**Standard 2 Requirements (3)(a), (3)(c), (3(d) and (3)(e)**

* Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences and risks to consumers’ health and well-being are identified and management strategies developed to enable staff to provide quality care and services.
* Ensure assessment and planning processes are undertaken in partnership with the consumer and others the consumers wish to be involved in these processes.
* Ensure outcomes of assessment and planning are effectively communicated with consumers and/or representatives.
* Ensure consumer care plans are reviewed for effectiveness and/or updated in response to consumers’ changing condition and clinical incidents.
* 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) and (3)(b)**

* Ensure staff have the skills and knowledge to:
* provide personal and or clinical/care and services to consumers in line with their assessed needs and preferences and that is best practice, tailored to their needs and optimises their health and well-being; and
* provide appropriate care relating to management of skin integrity, wounds, nutrition and hydration, swallowing risks and falls.
* Ensure policies, procedures and guidelines in relation to best practice care and management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care and management of high impact or high prevalence clinical risks.

**Standard 4 Requirements (3)(b), (3)(c) and (3)(d)**

Ensure staff have the skills and knowledge to:

* identify, assess, review and monitor each consumer’s emotional and psychological care needs and preferences;
* identify things of interest to each consumer, implement activity programs in line with consumers’ preferences, engage them in activities of interest, monitor consumers’ level of engagement and review effectiveness of each consumer’s participation in the program; and
* Review processes relating to how information is communicated, in line with the intent of this Standard.
* Ensure policies, procedures and guidelines in relation to supporting consumers’ leisure and lifestyle needs and preferences are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to supporting consumers’ leisure and lifestyle needs and preferences.

**Standard 5 Requirement (3)(b)**

* Review cleaning processes, particularly those relating to consumers’ rooms and linen.

**Standard 6 Requirements (3)(c) and 3(d)**

* Ensure appropriate action is taken in response to feedback and complaints, including liaising with the complainant and using an open disclosure approach when things go wrong.
* Review processes to ensure all feedback and complaints are captured, including those received verbally and through email correspondence to enable emerging trends and improvement opportunities to be identified.

**Standard 7 Requirements (3)(a), (3)(b), (3)(c), (3)(d) and 3(e)**

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and preferences.
* Ensure workforce interactions with consumers are monitored.
* Ensure staff competency, 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 all eight of the Quality Standards.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken.

**Standard 8 Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e)**

* Review processes relating to how consumers are supported and engaged in the development, delivery and evaluation of care and services.
* Review processes relating to how the Board promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Review the organisation’s governance systems in relation to continuous improvement, workforce governance and feedback and complaints.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks and managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to open disclosure, as well as the non-compliance identified in Standard 3 Personal care and clinical care.