Performance

Report

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| Name: | Regis Port Coogee |
| Commission ID: | 7469 |
| Address: | 72 Pantheon Avenue, PORT COOGEE, Western Australia, 6163 |
| Activity type: | Site Audit |
| Activity date: | 23 January 2024 to 25 January 2024 |
| Performance report date: | 20 February 2024 |
| Service included in this assessment: | Provider: 3522 Regis Aged Care Pty Ltd  Service: 26123 Regis Port Coogee |

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

**This performance report**

This performance report for Regis Port Coogee (**the service**) has been prepared by M Roach, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the assessment team’s report received 15 February 2024.

# Assessment summary

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

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

# Areas for improvement

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

Standard 3 Requirements 3(3)(a), 3(3)(b) and 3(3)(d) - Ensure each consumer gets safe, effective and tailored clinical care, including the effective management of medication related high impact or high prevalence risks and consumers’ changed condition. This includes, but is not limited to:

* consistent monitoring and evaluation of blood pressure levels, fluid balance and weight to ensure best practice and tailored care delivery;
* safe and effective medication administration and monitoring, including consistent staff medication administration practice, documentation and understanding in medication incident management;
* timely and appropriate response to consumers’ changed condition or deterioration, including consistent consumer health status monitoring;
* information about the consumer’s changed condition, including changed medication regime, is documented and effectively communicated within the organisation; and
* ensure effective clinical monitoring mechanisms are in place to identify and rectify practice deficits.

Standard 8 Requirements 8(3)(c) and 8(3)(d)

* Ensure effective organisational governance systems in information management.
* Ensure all medication incidents are reported, captured and reviewed/investigated appropriately, including using the incident management system to effectively prevent similar incidents.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and representatives said staff treat consumers with dignity and respect, know them well, support them to exercise choice and independence and respect their privacy. They also advised consumers are supported to take care related risks to enable them to live the best life they can; this includes being involved in decision making, risk assessment and risk mitigation processes.

The organisation has a suite of policies to guide staff practice. These include Spiritual support and cultural safety of consumers’ well-being, Consumer choice and independence, and Dignity of risk. Staff demonstrated knowledge surrounding dignity of choice and provided examples of individualised strategies to support consumers maintaining relationships and culturally safe care delivery. Sampled care planning documents evidenced consumers’ individual choices around when care is delivered, who is involved in their care and how the service supports them in maintaining relationships. Observations showed staff interacting with consumers in a way that respects their dignity.

Information provided to consumers is communicated clearly and easy to understand. Information is provided through a range of avenues, including information displayed at the service, meeting forums, individual discussions and newsletters. Consumers were happy with the information provided to them and described the information as helping them to exercise choices. The organisation has policies and procedures in place to ensure consumer privacy is respected and confidentiality of consumers’ information is maintained. Staff were observed knocking on doors and asking for permission before entering consumer rooms and providing care in an area that is private. Information on the electronic documentation system is secured with usernames and passwords ensuring restricted access.

Based on the evidence and reasons detailed above, I find all 6 specific Requirements under Standard 1 compliant. Consequently, I find Standard 1 Consumer dignity and choice compliant.

# Standard 2

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

Findings

Consumers and representatives expressed satisfaction with the level of involvement in the assessment, care planning and care plan review process. They advised the service identified risks and uses the information to plan consumers’ care. In addition, consumers and representatives confirmed they can access care plans.

The service has systems and processes to support consumer-centred assessment and care planning. Care files included initial assessments and care plans that addressed consumers’ needs, goals and preferences, including care related risks identified. Care planning documentation evidenced the inclusion of consumers’ preferences and current care needs, things and people important to them to maintain their health and well-being and end of life wishes. Whilst one consumer’s care plan did not reflect their current needs regarding the frequency of blood pressure measurements, this was considered as part of Requirement 3(3)(a) from a best practice angle. Care files also demonstrated various external health providers are involved in the assessment and planning process. Documented care plans were readily accessible to all staff providing care and services via the service’s electronic file system.

Consumers’ care plans are reviewed in accordance with the review schedule. The service has policies and procedures to guide staff practice in care plan review process, including reassessing consumers’ physical, intelligential, emotional, cultural and social needs. Staff confirmed they review and update consumers’ care plans if consumers’ circumstances change.

Based on the evidence and reasons detailed above, I find all 5 specific Requirements under Standard 2 compliant. Consequently, I find Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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

Findings

In relation to Requirement 3(3)(a), the assessment team were not satisfied with the delivery of safe and effective clinical care. The assessment team identified below deficits.

* Ten sampled consumers’ clinical care needs were not effectively managed, including:
  + A named consumer had inconsistent blood glucose monitoring instructions between care plan and electronic system prompts. The consumer did not have their blood glucose level measured twice daily for 10 of 22 days, whilst the electronic system prompts staff to do so.
  + A second named consumer did not have weekly weighing completed for nearly 4 consecutive weeks despite their cardiac related medical background and weight gain. Whilst reviewed by a medical practitioner during the weight gain, the medical practitioner’s order of as required diuretic medication was not administered.
  + A third named consumer did not have their weekly weighing completed as per schedule. Whilst a fluid balance chart had been implemented to monitor fluid intake and output, the chart was not completed consistently to ensure accurate monitoring.
  + Despite condition change and requiring relevant monitoring, two named consumers did not have daily weighing or daily blood pressure measurements completed consistently.
* The service does not have a process to measure fluid in water jugs that are in consumers’ rooms and to include the amount consumed in fluid balance charts.
* The service’s clinical monitoring mechanisms, such as daily notes review and additional management ‘spot checks’, are not effective in identifying deficits.

The provider, in their response to the assessment team’s report, disagreed with most of the assessment team’s findings and submitted clarifying, additional and commentary information.

* In relation to the 5 named consumers:
  + For the first named consumer, the provider advised there was no evidence to support the consumer was requiring twice daily blood glucose level monitoring.
  + For the second named consumer, the provider explained that weekly weight monitoring was not related to the consumer’s cardiac medical background and the weekly monitoring frequency was changed to monthly at the end of November 2023. The provider clarified that the consumer was taking regular diuretics, and they did not show signs or symptoms that indicated a need for the as required diuretics.
  + For the third named consumer, the provider clarified weekly weight monitoring was commenced based on a representative’s request and was not related to the consumer’s medical background or clinical condition. The provider acknowledged the deficit relate to ‘charting’ and stated the consumer’s weight had been stable.
  + For the fourth and fifth named consumers, the provider submitted progress notes, external medical records and monitoring records and provided information under both Requirements 3(3)(a) and 3(3)(d). The provider advised an opportunity for improvement has been identified relating to charting.
* The provider stated:
  + A comprehensive process is now in place to manage consumers’ fluid restrictions, including consideration of the provision of water jugs in consumers’ rooms.
  + Education has been initiated to reinforce the procedures for managing fluid restrictions and meeting documentation requirements.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I am of the view that the provider is not delivering effective and best practice personal and/or clinical care which is tailored to consumers’ needs for 3 consumers in relation to the monitoring of blood glucose levels and weights. I find the service’s clinical oversight mechanisms being ineffective, including fluid intake monitoring and evaluation processes.

In relation to the named consumers:

* For the first named consumer, I am persuaded by the provider’s evidence, including progress notes and blood glucose level measurement records and came to a view that there was a lack of evidence supporting the twice daily blood glucose level monitoring requirement. However, based on the provider’s submission, I agree with the assessment team’s finding that the consumer had inconsistent blood glucose monitoring instructions for a period of time. Whilst the consumer’s medical practitioner instructed to monitor blood glucose levels daily, the consumer’s care plan instructed staff to check blood glucose levels weekly. Although the consumer’s tailored blood glucose level monitoring was delivered, I find contradictory monitoring frequency information is not best practice to guide staff consistent practice.
* In relation to the second named consumer’s experience, although I acknowledge that the provider advised the consumer’s weight monitoring frequency should be monthly from the end of November 2023 and the monthly weight had been completed, I was not provided sufficient evidence to confirm the monthly weighing requirement. Regarding the use, or not use, of the as required diuretics, neither the assessment team nor the provider gave sufficient and relevant evidence on the consumer’s clinical condition. Therefore, I have not placed weight on this matter under this specific Requirement.
* Regarding the third named consumer’s experience, I acknowledge that there was no adverse consumer impact whilst the weekly weighing was not completed consistently. The provider’s submission indicated the weekly weight measurement was a result of collaborating with the consumer’s representative, therefore, I am of the view that the consumer did not receive effective care that is tailored to their needs. I place weight on the assessment team’s finding on ineffective oral fluid intake monitoring. In addition, whilst I acknowledge the provider’s acceptance on the ‘charting’ gap, I find the deficits relate to personal and/or clinical care delivery rather than a lack of documentation.
* For the fourth and fifth named consumers, I acknowledge the information provided by both the assessment team and the provider. Based on the 2 consumers’ experience relating to monitoring and management following condition change, I will consider this information under Requirement 3(3)(d).

Whilst I acknowledge the provider’s statement regarding a comprehensive process is now in place to manage consumers’ fluid restrictions, I place little weight on it because I was not provided with any evidence to demonstrate the current oral fluid intake monitoring and evaluation practice is effective and best practice, including whether staff consider and document the amount of fluid consumed by consumers prior to water jugs in their rooms being changed.

I acknowledge the provider is taking improvement actions, including providing education to staff in relation to fluid restriction management and documentation. However, I was not provided with evidence in relation to the progress, completion or effectiveness of the training. Therefore, I place weight on improvement actions not having been fully completed, requiring time to be embedded within the service’s normal processes, and testing to ensure their effectiveness and sustainability.

In addition, I am persuaded by the assessment team’s report on the ineffective clinical oversight mechanisms. As such, this finding is also based on the service’s own monitoring mechanisms, including daily notes review and management ‘spot checks’, which did not identify and then rectify the deficits, prior to it being identified by the assessment team, to ensure effective and best practice personal and/or clinical care which is tailored to consumers’ needs.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(a) non-compliant.

In relation to Requirement 3(3)(b), the assessment team were not satisfied high impact or high prevalence risks relating to medication had been effectively managed. The assessment team brough forward:

* A named consumer did not receive a prescribed medication (medication T) on 21 days in December 2023 based on medication administration records. The consumer was administered diabetic medication (medication E and M) that were supposed to be withheld on multiple occasions in January 2024.
* A second named consumer required their packed medication manually adjusted to match their medication order. Although the medication should be administered by registered staff only, documentation evidenced the medication was administered by care staff.
* The service’s medication administration monitoring mechanism is ineffective as whilst management review missed medication reports, there was no evidence to support these medication incidents had been reviewed or investigated. For example, the first named consumer did not receive medication T on 21 days and the service had not investigated this or completed an incident report. Missed medication for 2 consumers had no reason or incident report completed.
* Whilst care staff assist with medication administration, consumers’ medication changes are documented on clinical staff handover sheets which are not shared with care staff. This practice does not ensure up to date information is available to all staff who carry out medication duties. The assessment team used a medication incident with complete internal investigation, where a named consumer required hospitalisation after being administered ceased medication, to support the recommendation.

The provider, in their response to the assessment team’s report, disagreed with most of the assessment team’s findings and submitted clarifying, additional and commentary information.

* For the first named consumer, the provider advised an investigation had been undertaken. The provider explained the consumer’s medication was changed at the end of November 2023 and confirmed that the consumer received the medication T. The consumer’s medication was changed in January 2024 with medication E being ceased and staff had withheld medication M correctly. Medication chart with January 2024 administration record, progress notes, correspondence with the medical practitioner and external medical record from February 2024 were submitted as evidence.
* In relation to medication administration monitoring mechanisms, the provider advised the missed medication information for the 2 consumers was incorrect and submitted medication administration records and progress notes as evidence. The provider explained the process of using the electronic medication system to monitor medication administration to determine the appropriate next step, including documents clarifying information, such as medication had been administered or trigger an incident form.
* The provider explained the medication incident had been investigated prior to the site audit and remedial actions, including relevant education had been provided to staff. The cause of the incident was relating to delayed medical practitioner’s update in the electronic medication system and lack of handover between clinical staff and care staff with medication duties. The provider stated there had been no similar incidents at the service since.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I am of the view that medication related high impact or high prevalence risks were not effectively managed for 2 consumers on multiple occasions. I find the medication administration monitoring mechanism being ineffective and the service does not ensure changed medication information is available to all staff carry medication duties.

For the first named consumer, I was not persuaded by the provider’s response and evidence that the consumer received all their medication correctly in December 2023 and January 2024.

* I was provided with 2 paper-based medication profiles and medication administration records for 8 January 2024 to 22 January 2024. However, these documents do not evident that the consumer had received medication T correctly and consistently in December 2023. I also noted the morning medication on 15 January 2024, which includes medication T, was not signed as being administered.
* The 2 progress notes and correspondence with the medical practitioner evidenced registered staff checked medication against the paper-based medication profile after the medication change and contacted the medical practitioner to update medication information in the electronic medication system. I place little weight on these as they do not evidence correct and effective medication administration. In addition, I find the third progress note evidenced ineffective management of medication related risks as it reflected staff were administering medication based on the electronic medication system, which included incorrect information, 23 days after the medication change and paper-based medication profile/charting being used. Although no adverse outcome had been identified, I consider having paper-based and electronic medication systems that contained inconsistent medication orders concurrently place the consumer at high impact or high prevalence risks.
* I am persuaded by the provider’s clarifying information regarding medication E had been ceased based on this medication not listed on medication profile since the end of November 2023.
* In relation to medication M that was instructed to be withhold, I acknowledge that January 2024 medication administration records showed 6 of the 14 evenings the medication was not administered. However, I find 57% of the January 2024 medication administration record showed ineffective management of medication related risks based on:
  + medication M had been signed as administered on 2 of the 14 evenings; and
  + whilst 6 of the 14 evenings medication had been signed as administered, it is unable to be determined whether medication M had been withheld or administered based on the evidence submitted by the provider.

As there was no clarifying, additional or commentary information from the provider in relation to the second named consumer, I place weight on the assessment team’s finding and came to the view that registered and care staff medication administration/assistance practice was not in line with the organisation’s policy to ensure medication associated risks are effectively managed.

In relation to medication administration monitoring mechanisms, I place weight on the provider’s evidence that confirms the 2 consumers did not experience missed medication. Regarding the first named consumer’s medication experience in December 2023, I acknowledge the provider had completed an incident report and investigated matter. However, I find the medication administration monitoring mechanism ineffective in identifying and responding to missed medication or inconsistent documentation approach based on the internal investigation commenced after the assessment team raised concerns at the end of January 2024.

Regarding the medication incident where a named consumer required hospitalisation after being administered ceased medication, I have not placed weight on this matter under this specific Requirement because the provider had identified and investigated the incident prior to the site audit, as part of the internal incident management process. Although the provider stated there has been no further similar incident at the service, I find the medication administration deficits for the first named consumer had similar contributing factors, including delayed medical practitioner’s update in electronic medication system. This is further discussed in Standard 8 Requirement 8(3)(d) under the use of an incident management system to manage and prevent incidents.

I was not provided with clarifying, additional and commentary information or evidence to address the deficits brought forward by the assessment team in relation to care staff who carry out medication administration tasks and do not have access to medication change information documented on clinical staff handover sheets. Therefore, I find this process does not ensure up to date information is available to all staff who carry medication duties to enable effective management of medication related risks.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(b) non-compliant.

In relation to Requirement 3(3)(d), the assessment team identified consumers’ changed condition was not identified or responded to in a timely manner and brought forward below evidence.

* A named consumer experienced high readings of blood pressure that was significantly out of range. Despite medical practitioner’s request, blood pressure medication change and the consumer was reported as being unwell on 2 occasions within 6 days, the consumer’s blood pressure was not consistently monitored. When the consumer showed leg oedema, whilst the service identified the change there was no evidence that the condition had been referred to and reviewed by medical practitioner.
* The representatives of a second named consumer expressed concerns about staff monitoring and escalating changes. The consumer experienced shortness of breath and required hospital transfer which resulted in medication change, including increased dose of diuretics. However, the consumer’s vital signs observation and oral fluid intake monitoring were inconsistently completed during the condition change and prior to hospital transfer.
* A third named consumer’s condition deteriorated following a fall and experienced delayed hospital transfer.
* Five consumers requiring regular blood pressure monitoring did not have their desired range or escalation instruction in place.

The provider in their response to the assessment team’s report to the assessment team’s report, disagreed with some of the assessment team’s finding and submitted clarifying, additional and commentary information.

* For the named consumer, the provider explained the consumer’s medical background and provided the timeline of the identification and response to the consumer’s high blood pressure. The provider advised although the consumer required hospital transfer following a significant high reading of blood pressure at the end of December 2023, there was no blood pressure monitoring directive when the consumer returned to the service from the hospital. When the consumer experienced another episode of significant high blood pressure reading in early January 2024, the service arranged a review from the hospital’s emergency department and the consumer’s blood pressure medication had been titrated. The provider acknowledged the daily blood pressure monitoring was not completed as per medical practitioner’s directive, following the review, for 4 days in January 2024. The provider accepted this deficit as a ‘charting’ gap.
* Regarding the second named consumer’s experience, the provider acknowledged the consumer’s fluid balance charts and weight charts were not consistently completed and advised there had been no adverse outcome associated with inconsistent fluid balance and weight monitoring. The provider advised the consumer has a complex medical background, including chronic cardiac diagnosis and their shortness of breath should not be assumed as relating to the chronic cardiac diagnosis. A hospital discharge summary was submitted to evidence the consumer’s cardiac issue had been managed.
* The provider advised the delay in recognition of deterioration for the third named consumer had been identified, reported and investigated prior to the site audit and remedial actions, including relevant education had been provided to staff.
* The provider clarified the blood pressure monitoring process and explained consumers require ongoing monitoring with a medical directive in place would have desired blood pressure reading range and escalation instruction in place. An example of blood pressure monitoring directives was submitted as evidence.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I am of the view that the provider is not effectively monitoring 2 consumers’ conditions in response to their health status changes.

For the first named consumer, I acknowledge there was no medical directive in relation to blood pressure monitoring following the hospital discharge at the end of December 2023. However, I consider the consumer experienced significant out of range high blood pressure (repeat systolic reading above 200 mm Hg). Whilst there was no change in blood pressure medication made by hospital medical practitioners, frequent blood pressure monitoring would be essential, in response to the consumer’s marked elevation in blood pressure, to ensure the consumer’s blood pressure is within normal range or trigger timely escalation if elevated blood pressure is detected. I also find the consumer’s changed condition was not effectively managed as both the assessment team and the provider had confirmed, following a repeat episode of significantly elevated blood pressure (systolic reading above 200 mm Hg) and blood pressure medication change, the consumer’s daily blood pressure measurement was not completed as per medical practitioner’s directive for 4 days. Further, although I acknowledge the provider’s acceptance on the ‘charting’ gap, I find the deficits relating to lack of monitoring caused ineffective response to the consumer’s changed health status rather than a lack of documentation.

In relation to the second named consumer’s deterioration that required hospital transfer, I find the consumer’s changed condition was not effectively managed as both the assessment team and the provider had confirmed the consumer’s fluid balance and weight had not been consistently monitored. Considering the consumer’s complex health background and associated cardiac concerns, consistent monitoring will enable early detection of any actual or possible deterioration. However, based on the hospital discharge summary submitted by the provider and the assessment team’s report, I find the service did not effectively monitor or respond to the consumer’s deterioration whilst observed the consumer’s progressively increasing breathlessness and worsening lower limb swelling over a few days before the consumer’s representative requested the hospital transfer. I was not provided with evidence to demonstrate the consumer’s vital signs had been monitored frequently when the consumer experienced worsening shortness of breath. Whilst I acknowledge the consumer’s weight had been overall stable based on weight records submitted by the provider, I was not provided with information or evidence to be persuaded that the consumer’s fluid restriction had been effectively managed during or following the site audit. Although I am not in a position to determine whether the consumer’s shortness of breath was associated with their chronic cardiac condition, I place weight on the consumer’s adverse experience in presenting in hospital with worsening shortness of breath and exacerbation of chronic cardiac condition which required intravenous treatment to improve. In addition, I place weight on the consumer’s representative’s negative feedback in relation to the service’s inconsistent or lack of monitoring and ineffective escalation process.

Regarding the delayed recognition of deterioration for the third named consumer, I have not placed weight on this matter under this specific Requirement because the provider had identified and investigated the incident, prior to the site audit, as part of the internal incident management process. I am persuaded by the provider’s explanation and evidence submitted regarding the process of having desired blood pressure range and escalation instruction in place for consumers requiring ongoing monitoring.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(d) non-compliant.

For Requirements 3(3)(c), 3(3)(e), 3(3)(f) and 3(3)(g), I find them compliant based on the below evidence and reasons.

* Staff interviews and documentation review evidenced that the needs, goals and preferences of consumers nearing the end of life are recognised and addressed. This includes maintaining the consumer’s dignity, monitoring signs of pain and comfort level, and ensuring family members or the people important to the consumer could spend time with the consumer.
* Overall, sampled consumers and representatives stated that staff know consumers and what their care needs are. Care staff advised they are informed about consumers’ needs by clinical staff through handover process. The assessment team observed a number of different tools staff use to communicate information. Whilst tailored care is not always delivered and changed medication information is not communicated effectively between registered and care staff, these had been discussed in Requirements 3(3)(a) and 3(3)(b).
* Consumers or representatives confirmed consumers can see their general practitioners and other service providers in a timely manner. Clinical staff showed mutual understanding in the referral process and gave examples of when a referral would be made. Sampled consumer files showed the service’s process in ensuring timely and appropriate referrals to medical practitioners, allied health professionals and specialists.
* The service monitors infections and reviews the antimicrobials prescribed to ensure appropriate prescribing to reduce the risk of increasing resistance to antibiotics. Clinical staff gave example on when and how they collect specimens to support the appropriate antibiotic usage. Staff confirmed that they attend regular training in personal protective equipment (PPE) usage and hand hygiene. Staff also advised, in the recent COVID outbreak, they had sufficient PPE supplies and donning and doffing stations.

In summary, I find Standard 3 Personal and clinical care non-compliant based on 3 of the 7 specific Requirements have been found non-compliant.

# Standard 4

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

Findings

Consumers stated staff know them well and provide them with daily support and services which meet their needs and preferences. Consumers confirmed the service recognises their cultural, spiritual and emotional needs and staff provide adequate assistance and support. In addition, consumers advised they are supported to maintain meaningful social and personal connections within the community.

Sampled care planning documents evidenced information about the consumer’s history, pastoral care preferences and leisure and lifestyle needs to guide the provision of individualised care and services. Documentation showed consumers are engaging in their preferred lifestyle and leisure activity program and there are activities, within and outside the service, available to meet consumers’ individual preference and needs. The service has processes in place to ensure that information about the consumer’s condition, needs and preferences are communicated within the service and with others where care responsibility is shared. Timely and appropriate referrals to other service providers were evidenced, these include haircare, spa services, aromatherapy, emotional and/or spiritual support.

Staff provided examples of how they ensure consumers receive services and supports for daily living that promote their independence and well-being. These include providing and assisting consumers to use appropriate and/or specialised equipment, inviting community personnel into the service to spend time with consumers, running specific small group programs for consumers living with specific needs, implementing cultural-based activities for consumers who shared the same background, and supporting consumers to attend social activities outside of the service. Staff stated they check equipment to support consumers’ daily living before use and report to maintenance if any concerns. Equipment used to support consumers’ daily living, including specialised cutlery, mobility and hygiene needs aids, was observed to be safe, clean and well-maintained.

Consumers and representatives said meals provided are varied and of suitable quality and quantity. Consumers were observed having choices for their main meals and additional alternatives were also available. Staff described how they meet individual dietary needs and preferences. The service maintains a quarterly menu and has mechanisms to obtain consumer feedback on meals. Observations demonstrated a pleasant and welcoming dining experience using placemats, napkins and the display of current menu options within each dining space for supporting consumers’ meal choice.

Based on the evidence and reasons detailed above, I find all 7 specific Requirements under Standard 4 compliant. Consequently, I find Standard 4 Services and supports for daily living compliant.

# Standard 5

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

Findings

Consumers and representatives were satisfied with the service environment. They said the environment is safe, welcoming, clean and well maintained. Consumers advised furniture, fittings and equipment are safe and clean and did not voice any concern around maintenance work.

The service environment enables consumers to move freely both indoors and outdoors. There are indoor communal spaces and well-maintained outdoor garden areas for consumers to sit and relax or participate in activities. The walkways are fitted with handrails and there is signage throughout the service to make the service environment easy to understand. Consumer rooms were observed with personal belongings and decorating items relevant to the consumer’s interests and lifestyle.

Staff were observed cleaning consumer rooms and communal areas. Care staff explained the cleaning processes, especially how they sanitise shared consumer transfer equipment regularly and between use. Care staff also showed shared understanding on the process of submitting urgent and non-urgent maintenance requests.

The service has preventative and reactive maintenance programs, as well as mechanisms for reporting of maintenance issues and/or hazards, to ensure a safe environment. Maintenance records evidenced risk assessments to issues identified and timely follow up actions.

Based on the evidence and reasons detailed above, I find all 3 specific Requirements under Standard 5 compliant. Consequently, I find Standard 5 Organisation’s service environment compliant.

# Standard 6

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

Findings

Consumers and representatives said they are encouraged to provide feedback and complaints, through internal and external channels, and felt comfortable to do so. The majority of consumers and representatives advised complaints are managed in a timely manner and open disclosure principles were applied when things go wrong. Consumers and representatives expressed satisfaction in relation to how their feedback is used to improve care and services.

Readily available feedback forms, advocacy and language service, and external complaints resolution mechanism information were observed at the service. Management and staff encourage and support feedback mechanisms through consumer and representative meeting forums, newsletters and informal discussions. Staff are guided in the complaints management process by policies and procedures and advised interpreter services is available when required.

The service has processes to ensure feedback provided or complaints raised are captured, actioned and reviewed. Management described the process to analyse feedback and complaint data. Staff interview and review of documentation, including meeting minutes and continuous improvement plan, confirmed feedback and complaint information is used to drive improvement to promote quality care and services.

Based on the evidence and reasons detailed above, I find all 4 specific Requirements under Standard 6 compliant. Consequently, I find Standard 6 Feedback and complaints compliant.

# Standard 7

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

Findings

Most consumers and representatives confirmed there are adequate numbers and mix of staff. Most consumers and representatives voiced confidence in the ability of staff performing their duties and have the skills and knowledge to deliver safe and quality care and services. Observations showed staff and consumers’ interaction to be compassionate, kind, caring and respectful.

Staff stated they feel supported, receive mandatory and additional training relevant to their role, and have sufficient workforce most of the time to deliver consumer care and services. They demonstrated knowledge of individual consumers’ needs, preferences and personalities and where they could find additional information if required. Staff confirmed they are encouraged to give feedback and there is a lot of training being delivered.

Management described ways of monitoring staffing levels across the service to meet consumer needs, including review of call bell analysis, monitoring incidents and complaints, discussing at staff meetings and consumers and representatives meetings. Recruitment processes are supported by the wider organisation and the service has systems and procedures to guide onboarding process and support staff training. A role specific matrix and duty statements that outline expectations are in place to guide staff practice.

Management monitor staff competency through direct observation, a review of staff performance appraisals, feedback from senior staff, review of incidents, monitoring of clinical indicators and feedback from consumers and their representatives. Staff performance assessments are completed during probationary period and annually. In addition to onboarding process and mandatory trainings, the service undertakes investigation into practice deficits and addresses the deficits via additional training, toolbox sessions, additional monitoring and a formal performance management approach if required.

Based on the evidence and reasons detailed above, I find all 5 specific Requirements under Standard 7 compliant. Consequently, I find Standard 7 Human resources compliant.

# Standard 8

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

Findings

In relation to Requirements 8(3)(a), 8(3)(b) and 8(3)(e), I find them compliant based on the below evidence and reasons.

* Consumers described involvement in the development, delivery and evaluation of care and services, such as at care plan reviews, conversations with management, regular consumer meetings and surveys. A consumer advisory committee is being established with 2 consumers and 3 representatives. The organisation has systems in place to capture consumer feedback. The Plan for Continuous Improvement (PCI) demonstrates improvements made as a result of consumer feedback and suggestion.
* Most consumers and representatives interviewed stated they felt the overall running of the service has improved. Documentation showed monthly performance level information is captured and analysed. Trended graphs have explanatory comments and actions for improvement are documented and communicated up to the Board level.
* The organisation has a clinical governance framework to support the delivery of care and services for consumers at the service. The service has structured workforce and systems and processes to support clinical staff to practice open disclosure and deliver care that promotes appropriate antimicrobial stewardship. Whilst ineffective clinical care delivery relating to medication management and the monitoring of blood glucose levels, weight, fluid restrictions and blood pressure had been identified for several consumers, these have been discussed in Standard 3 and other Requirements under this Standard.

In relation to Requirement 8(3)(c), the assessment team found the organisation has a governance framework, which includes embedded meeting structures, monitoring and reporting systems, assigned delegations and accountabilities, and policies and procedures. There was demonstration of effective systems in relation to continuous improvement, financial and workforce governance, adherence to regulatory compliance and managing feedback and complaints. However, the assessment team were not satisfied with effective organisation wide governance systems relating to information management and brought forward:

* Consumers’ medication profiles are not always updated in a timely manner following a medication change. Care staff with medication duties rely on verbal handover from registered staff regarding the changed medication which increases the risk of medication errors occurring.
* When consumers required their packed medication manually adjusted to match their medication order, care staff with medication duties, registered staff and management described different practice in relation to who is responsible in performing the manual adjustment.
* For consumers using paper-based medication charts and had medication adjusted by medical practitioners, the charting section had limited space for documenting which medication had been administered. Staff also have inconsistent approach on where to document withheld, ceased, not stocked and/or administered medication.
* There had been no contemporaneous documented evidence to show follow up action when there had been missed medication identified by the electronic medication system.
* Incomplete or inconsistently complete clinical monitoring records, such as fluid balance charts and weight monitoring records, pose a risk of delayed identification of consumer condition change.
* There had been no process in place for staff to accurately record consumers’ oral fluid intake, including the consideration of water consumed from the water jug in consumers’ rooms.

The provider, in their response to the assessment team’s report, referred to responses of individual consumers under Standard 3 Requirements 3(3)(a), 3(3)(b) and 3(3)(d) and disagreed on the system failure on information management. The provider explained that the service had invested in the medication system since November 2022 to ensure an efficient medication administration process. In addition to reference of the improvement opportunities identified, as part of the responses for Standard 3 Requirements 3(3)(a), 3(3)(b) and 3(3)(d), relating to charting and monitoring, the provider advised immediate actions about medication management were implemented during the site audit, including:

* Ensuring all consumers’ medication charts are on the electronic medication system.
* Clarifying and implementing a written process for the management of medication changes.
* Initiating staff education to remind them the process around the correct codes within the electronic medication system and the procedure related to medication changes.
* Conducting education and reminders on what constitutes a medication incident.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I agree with the assessment team’s recommendation and finds organisational governance systems are effective regarding continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. However, I am of the view that the information management system was ineffective in relation to clinical communication, monitoring and documentation, including medication administration and management.

I place weight on multiple consumers’ incorrect or inconsistent medication administration records, and clinical monitoring records relating to fluid restriction and weight, regardless of whether an adverse outcome had been resulted. Whilst consumer privacy had been considered, I find the current process of handover and documentation or handover notes sharing practice not giving appropriate members of the workforce access to information that helps them in their roles. This include information on consumers’ changed care needs, such as changed medication regime. I have considered a consumer’s paper-based medication administration record that was submitted by the provider and agreed with the assessment team’s view that paper-based medication charts had its documentation limitation, following a change of medication regime, to ensure safe and correct medication administration. In addition, I have considered evidence and findings for Standard 3 Requirements 3(3)(a), 3(3)(b) and 3(3)(d) and place weight on inaccurate or inconsistent documentation which may have led to missed or delayed identification of consumers’ condition change or deterioration.

I acknowledge the provider has been taking improvement actions in relation to medication management, clinical monitoring and charting. However, I was not provided with evidence regarding the progress, completion or effectiveness of these improvement actions. Therefore, this finding is also based on improvement actions not having been fully completed, requiring time to be embedded within the service’s normal processes, and testing to ensure their effectiveness and sustainability.

Based on the evidence and reasons detailed above, I find Requirement 8(3)(c) non-compliant.

In relation to Requirement 8(3)(d), the assessment team were satisfied with the origination’s risk management systems and practices relating to managing risks associated with the care of consumers, identifying and responding to abuse and neglect and supporting consumers to live the best life they can. However, the assessment team were not satisfied with the organisation’s risk management systems and practices to managing and preventing incidents. The assessment brought forward:

* Not all medication incidents had been reported. When medication incidents occur, not all incidents had been reviewed or investigated. Whilst some medication incidents had been investigated, the investigation is not robust to identify root causes and system deficits to prevent further similar incidents. Quality reports do not reflect the actual amount of medication incidents.
* The investigation of a consumer’s falls incident did not result in a detailed review of existing strategies in place and the consumer experienced a further fall with similar circumstances.

The provider, in their response to the assessment team’s report, referred to responses of 3 individual consumers under Standard 3 Requirements 3(3)(a), 3(3)(b) and 3(3)(d) and disagreed on the system failure on incident management and prevention. The provider advised the 3 consumers either received their medication correctly or the medication incidents had been effectively reported and investigated. The provider also referenced their response under Standard 3 Requirement 3(3)(b) regarding missed medication. In addition, the provider submitted clarifying and additional information regarding the consumer’s falls incidents and internal investigation.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I find the organisation has effective risk management systems and practices in identifying and responding to abuse and neglect of consumer and supporting consumers to live the best life they can.

However, I am of the view that the risk management systems and practices are not effectively managing high impact or high prevalence risks associated with consumers’ care. I am persuaded by the deficits in the management of multiple consumers’ care related risks, as outlined in the findings of non-compliance in Standard 3 Requirements 3(3)(a), 3(3)(b) and 3(3)(d), including, but not limited to, ineffective medication administration and monitoring posing risks, inconsistent fluid intake monitoring and evaluation for consumers requiring fluid restriction, lack of or inconsistent monitoring in response to consumers’ marked elevation in blood pressure levels or worsening breathlessness. My finding is also based on the ineffective clinical oversight mechanisms, including daily documentation review, management ‘spot checks’, review of missed medication report and use of quality reports with analysed incident information, which did not identify and then rectify all deficits, to ensure consumers’ care related risks are effectively managed.

Further, whilst I am persuaded by the additional information submitted by the provider in relation to a consumer’s falls incident and investigation process and outcome, I find the organisation’s incident management system and practice are ineffective in managing and preventing medication incidents. I place weight on the significant difference in total medication incident captured by the organisation’s quality report and missed medication report generated by the electronic medication system. I acknowledge, as outlined in in Standard 3 Requirements 3(3)(b), missed medication report is a practice for management to review and ensure all medication had been administered correctly and timely and not all missed medication qualify medication incident after been reviewed. However, I was not provided with sufficient information or evidence to be persuaded that all medication incidents had been reported and included in the quality report. I am not satisfied the medication incident investigation process is robust. As outlined in Standard 3 Requirements 3(3)(b), whilst the provider had completed an investigation and confirmed the first named consumer had received all their medication correctly, I was not persuaded that the consumer’s medication had been effectively managed in December 2023 and January 2024. I place weight on the incident management being ineffective to prevent similar incident. Following a medication incident investigation completed in November 2023 which identified causation factors including delayed medical practitioner’s update in electronic medication system, education was provided to staff to contact medical practitioner via phone to reduce the risk of medication error. Whilst the provider stated there has been no further similar incident at the service, I find the medication management deficits for the first named consumer outlined in in Standard 3 Requirements 3(3)(b) experienced similar causation factors.

Based on the evidence and reasons detailed above, I find Requirement 8(3)(d) non-compliant.

In summary, I find Standard 8 Organisational governance non-compliant based on 2 of the 5 specific Requirements have been found non-compliant.

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