RFBI Basin View Masonic Village

Performance Report

130 The Wool Road   
BASIN VIEW NSW 2540  
Phone number: 02 4443 5034

**Commission ID:** 0624

**Provider name:** Royal Freemasons' Benevolent Institution

**Site Audit date:** 24 May 2022 to 26 May 2022

**Date of Performance Report:** 19 July 2022

# Performance report prepared by

Susan Turner, 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** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Non-compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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 staff, consumers/representatives and others
* the provider’s response to the Site Audit report received 24 June 2022, 8 July 2022 and 12 July 2022

The approved provider in its response to the site audit report outlined a number of externally impacting factors which were said to be responsible, or partly responsible, for deficits in care or services provided. These included the effect of the 2020 bushfires in New South Wales, the collapse of the ceiling in the main dining room (as a result of the extreme heat associated with the bushfires), flooding and COVID-19 for the preceding two years. The approved provider said that as a result of these factors that tradespeople and contractors could not access the building for extended periods of time. Within this performance report these matters are referred to as external factors.

While these external factors are not disputed the approved provider remains accountable for delivering safe, quality care and services and ensuring that it complies with the Aged Care Quality Standards.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Consumers and representatives said that staff speak to them respectfully and generally know and respect consumers’ preferences. Consumers and representatives said staff support consumers to exercise choice including when their choices involve an element of risk, and most were satisfied that the service valued their culture and diversity and said that care and service delivery is safe.

Consumers and representatives provided examples of how the service supported them to maintain relationships including during the COVID-19 pandemic when the service assisted by facilitating telephone calls.

Consumers confirmed they are provided with current information through various mechanisms including meetings, activity programs and on entry. Consumers said they are always able to approach management or staff directly if they need to know something. Information provided to consumers includes the Charter of Aged Care Rights, information from the Aged Care Quality and Safety Commission, internal and external complaints mechanisms and the Older Person’s Advocacy Network.

The organisation has dignity of risk protocols and policies relevant to this standard including consumer privacy and confidentiality. Consumer files were secured and computers were password protected.

Management said consumers participate in decisions about the services they receive and are enabled to exercise choice and control over their lifestyle. Consumers’ representatives act as support and decision makers when the consumers’ cognition is impaired and the Assessment Team saw evidence of this in care related documentation.

Staff spoke about consumers respectfully demonstrating familiarity with consumers and an understanding of their personal circumstances, preferences and life journey. Staff were familiar with the strategies they would use to aid communication and said that when appropriate, they talk slowly, take additional time to explain and enlist the assistance of the consumer’s representative. Staff said they are always mindful of being discreet when discussing consumers with their colleagues and described the ways they promote and support consumers’ privacy.

The Assessment Team observed notices displayed throughout the service providing details about the lifestyle program, menu choices, complaints information advocacy services and information advising consumers and representatives of the site audit.

The Quality Standard is assessed as compliant as six of the six specific requirements have been assessed as compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

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

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

*Care and services are culturally safe.*

Consumers and representatives were generally satisfied and most said that care and services were culturally safe. Consumers provided examples of days that are culturally significant for them including Anzac Day.

Lifestyle staff said they have supported consumers to celebrate their culture throughout the year. This included for example respecting Anzac Day and Remembrance Day.

Care planning documents reflected what is important to consumers and included a lifestyle assessment that is completed in consultation with the consumer and/or their representative. Cultural and personal preferences were documented including culturally specific information such as country of birth and languages spoken.

The Assessment Team brought forward information that the cultural needs and preferences for one named consumer were not being met and that this had resulted in the consumer not having access to a food they enjoy. The site audit report included information that lifestyle staff could not demonstrate that culturally specific days/events, relevant to this consumer were reflected in the lifestyle program.

The approved provider refutes the Assessment Team’s findings and asserts that culturally safe care is provided to consumers including the named consumer. It states that information about the consumer’s life history and cultural needs are identified on entry to the service and are updated on an ongoing basis. The approved provider included evidence that the service considers consumers’ cultural needs and preferences in assessment and care planning processes. Evidence submitted included ‘key to me’ documentation, assessments, consumer profiles, entry information, care plans and other relevant documentation.

With respect to the named consumer the approved provider asserts that there has been ongoing involvement with both the consumer and the authorised decision maker about care and services since the consumer’s entry to the service and evidence of this including a recent case conference was provided. I acknowledge that references to the consumer’s cultural needs and preferences were captured in initial and ongoing care planning documentation. The approved provider has addressed the information brought forward by the Assessment Team and has purchased additional catering equipment, is providing additional foods in accordance with the feedback provided during the site audit and has reviewed the service’s plan for continuous improvement.

I have considered the information in the site audit report together with information submitted by the approved provider. I have given particular weight to the generally high levels of satisfaction reported by consumers and representatives under this requirement and I am satisfied that consumers receive culturally safe care and services.

I find this requirement is compliant.

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Compliant

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

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

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

# STANDARD 2 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

Most consumers and representatives interviewed by the Assessment Team expressed satisfaction with their level of involvement in assessment and care planning processes. Consumers and representatives said staff generally knew what consumers wanted in terms of their care and service needs and provided examples of how staff met their preferences when assisting them with activities of daily living.

Care staff described how assessment and planning processes inform the delivery of care. Care staff were familiar with how they can access information about the consumer; this included through the summary care plan, the extended care plan in the electronic care management system and through handover processes.

Registered staff explained that case conferences are held at the time of entry to the service, annually and as needed. They said that following a case conference a copy of the care plan is provided to the consumer and/or their representative.

Care plans generally included consumers’ needs, goals and preferences and advance care plans were in place for most consumers. Care planning documentation reflected the involvement of the consumer, authorised decision makers, medical staff and allied health professionals in the assessment and care planning process. Including for example, a dementia advisory service, geriatricians, Older Persons Mental Health, podiatrist, physiotherapist, speech pathologist and nurse practitioner.

Care plans demonstrated reviews of consumers’ care and service needs occur on a regular basis and following a change in the consumer’s condition. The Assessment Team brought forward evidence that a review of care occurred following the development of a pressure injury and falls.

Policies relevant to this standard are available to guide staff practice and include end of life.

The Quality Standard is assessed as compliant as five of the five specific requirements have been assessed as compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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.*

Consumers expressed satisfaction with assessment and care planning processes and some representatives stated they had been involved in the signing of dignity of risk documentation.

The organisation has policies and procedures in place relevant to this standard and there is a guide that supports registered nurses in the completion of assessments for new consumers on entry to the service. Processes include a requirement for the care manager to assist registered nurses in the assessment and care planning process, ensuring that a consideration is given to risk.

Staff interviewed by the Assessment Team described how they use assessment and planning to inform the delivery of safe and effective care. Staff said all consumers are assessed on entry and are to be re-assessed when their health needs change.

The Assessment Team found that assessment and care planning processes generally reflected consumers’ needs in relation to their health and well-being. However, the Assessment Team brought forward information that risk was not consistently considered for some consumers including those with complex behaviours and those who smoke cigarettes.

The approved provider in its response to the site audit report included care related documentation demonstrating that risk is considered in assessment and care planning. Evidence included email correspondence with families, case conferences, dignity of risk forms, behaviour support plans, managed risk negotiated agreement and care plan reviews.

I am satisfied that assessment and care planning processes include consideration of risks to the consumer’s health and well-being.

I find this requirement is 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) 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.*

### Requirement 2(3)(d) Compliant

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

### Requirement 2(3)(e) 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.*

# 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

Most consumers and representatives were satisfied with the personal and clinical care consumers received and said it is safe and right for them however mixed feedback was received from the representatives of consumers who reside in the memory support unit. Some consumer representatives raised concerns about staffing and the impact on care delivery including the management of complex behaviours and provided examples of how this had negatively impacted consumers.

Positive feedback was received from consumers or representatives about end of life care, referral processes, incident management, management of COVID-19 and communication processes generally.

Care planning documentation evidenced involvement of consumers, authorised decision makers, medical officers, allied health specialists, mental health services and a nurse practitioner. Consumers’ preferences relating to end of life care are documented and planning occurs to ensure the consumer’s comfort is maximised and their dignity is preserved as they approach this phase of their life.

For consumers who had experienced a change or deterioration in their condition, documentation indicated that the change was identified and responded to in a timely manner. The Assessment Team brought forward evidence that where appropriate, referrals were made to other health specialists, case conferences occurred and the nurse practitioner was involved.

Staff described the communication processes that are in place at the service including a verbal handover and the electronic information management system. They could provide examples of how they had cared for consumers who had become unwell including those consumers with an infection, weight loss or following a fall. In most instances, staff demonstrated an awareness of consumers’ care requirements however there were occasions when staff did not have a shared understanding of consumers’ needs including in relation to behaviour management.

Registered nurses were observed relaying pertinent information about consumers to other registered nurses and could describe referral processes.

Registered nurses demonstrated a general understanding of antimicrobial stewardship and the principles of infection control including those relating to outbreak management and standard precautions. The service has an infection prevention and control lead and demonstrated a preparedness in relation to COVID-19.

Staff said they have access to policies and guidance material relevant to this standard including for example recognising and responding to a deterioration in the consumer’s condition and anti-microbial stewardship.

However, deficiencies were identified in the service’s processes relating to the delivery of personal and clinical care, particularly in relation to behaviour management and the management of high impact and high prevalence risks.

The Quality Standard is assessed as non-compliant as two of the seven specific requirements have been assessed as non-compliant.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team brought forward information demonstrating that consumers, particularly those residing in the memory support unit are not consistently receiving care that is tailored to consumers’ needs and optimises their health and well-being.

The Assessment Team received mixed feedback from consumers and representatives. While feedback relating to care and services provided to consumers residing in the general area of the home was, for the most part positive, some representatives of consumers who reside in the memory support unit were dissatisfied with care and services. Representative feedback included concerns about lack of staff, lack of consumer engagement, consumers entering other consumer’s rooms and poor behaviour management practices. Representatives also raised concerns about the delivery of personal care including handwashing, cleaning of dentures and nutrition.

Staff interviewed said that there is ineffective communication of consumers’ behaviours and that strategies to manage the behaviours are not consistently tailored to the individuals.

Staff interviewed by the Assessment Team did not have a shared understanding of behavioural triggers or interventions to be used for some consumers with complex behaviours who reside in the memory support unit.

For one named consumer with ongoing complex behaviours, that include aggression, agitation and anxiety, the Assessment Team brought forward information that behavioural triggers have not been identified by staff, that the effectiveness of strategies used by staff in managing the behaviours were often not effective and that staff did not record the effectiveness of interventions used. The Assessment Team found that the behaviour support plan had not been reviewed for approximately six months and lacked sufficient detail to guide staff. Clinical documentation reviewed by the Assessment Team did not include evidence that staff have used documented strategies to manage or mitigate the consumer’s behaviour.

The Assessment Team observed this consumer asleep and seated in a wheelchair next to a consumer who was banging the table and singing loudly. The consumer’s behaviour support plan stated that noise was a trigger for behaviours of concern that included anxiety, agitation and aggression. Staff interviewed by the Assessment Team stated the consumer should not be seated there and said that if the consumer woke up they would become agitated and possibly aggressive; however, the Assessment Team noted the consumer was not moved to a quieter area.

The approved provider in its response to the site audit report provided organisational policies stating that behaviour support plans are to be reviewed as needed and at least 12 monthly. The behaviour support plan for the named consumer was submitted and evidenced details relating to personal and social history, cultural background, lifestyle habits, goals, restrictive practices, individualised interventions and factors that may contribute to behaviours of concern. Additional care related documentation included assessments, care plan and a restrictive practice authorisation. However, the approved provider’s response failed to address concerns raised by the Assessment Team that clinical documentation did not include evidence that documented strategies had been used and that strategies used by the staff to manage the consumer’s behaviour were often not effective. Additionally, the approved provider has not addressed why staff failed to remove the consumer from a noisy environment which is known to trigger behavioural episodes. I note that the approved provider submitted the named consumer’s behaviour support plan where it clearly states that a behaviour support goal is to provide a calm and gentle environment for the consumer and to seat the consumer in a quiet area.

For a second named consumer with ongoing complex behaviours that include aggression, agitation, verbal disruption and socially inappropriate behaviours the Assessment Team found that strategies included in the behaviour support plan to manage behaviours are general and do not address the consumer’s individual needs, including communication needs. The Assessment Team state the behaviour support plan evaluation that was last completed in March 2022 stated the consumer had settled into the memory support unit however progress notes and behaviour charts demonstrated the consumer continued to be physically threatening, aggressive and socially inappropriate. The Assessment Team state that in some instances behaviours of concern were lasting for more than one hour and interventions used were documented as being ineffective. Additionally, the Assessment Team identified concerns in relation to pain management and bowel management for this consumer. Documentation indicated staff were not consistently responding to the consumers’ pain and in one instance the consumer was recorded as not having had a bowel motion for a period of eight days with no action taken.

The approved provider’s in its response to the site audit report submitted care related documentation for the named consumer including the behaviour support plan, assessments, care plan and restrictive practice assessment and authorisation. However, the approved provider’s response failed to address concerns raised by the Assessment Team that the consumer continued to display ongoing behaviours that impacted their well-being and the well-being of others and that interventions used were found to be ineffective. The response did not address concerns relating to bowel management and pain management for this consumer.

The Assessment Team reviewed clinical documentation for one named consumer who was administered a chemical restraint during the site audit. The Assessment Team found that non-pharmacological interventions were not documented as being trialled prior to administration of the medication.

The approved provider submitted evidence of the named consumer’s behaviour support plan, assessments, care plan and restrictive practices authorisation. While I note that the documentation includes non-pharmacological interventions to support the consumer’s behaviour, the approved provider’s response has not addressed the concerns raised by the Assessment Team that staff are not documenting the interventions trialled prior to using chemical restraint.

The site audit report includes information that the management team provided the Assessment Team with an action plan that included strategies to improve behaviour management processes. Actions included a gap analysis and review of the clinical documentation (assessments, care plans, pain charts, dignity of risk forms and restraint documentation).

The approved provider in its response to the site audit report demonstrated that it has policies, procedures and templates to support the development of behaviour support plans. Behavioural assessments occur and there are processes to support the assessment and authorisation of restrictive practices. The staff education calendar has included the care of consumers living with dementia, behavioural and psychological symptoms of dementia and minimising restrictive practices. The plan for continuous improvement includes actions to improve the non-pharmacological management of complex behaviours.

Information brought forward by the Assessment Team in relation to consumer access to the courtyard in the memory support unit has been considered under Standard 5 and information about staff knowledge of restrictive practices has been considered under Standard 7.

While the service has policies and procedures relating to personal and clinical care, including behaviour support and restrictive practices, these were not consistently applied and for some consumers care was not tailored to their needs and did not optimise their well-being. Consumers experienced ongoing episodes of complex and challenging behaviours that impacted their well-being and that of others.

I find this requirement is non-compliant.

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

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

While the service has processes relating to the management of high impact and high prevalence risks, the risks associated with exit seeking behaviours and cigarette smoking have not been effectively managed.

The Assessment Team brought forward information that a named consumer, who has cognitive impairment, has a history of smoking in their room and has left the service without notice.

The Assessment Team in the site audit report raised concerns about incomplete incident documentation and inappropriate strategies to manage risks. The site audit report includes information that following a recent incident of possible smoking inside the service, the consumer was reminded to smoke cigarettes in the designated smoking area.

The approved provider in its response submitted evidence of a high impact, high prevalence risk register that determines the named consumer to be at high risk due to multiple factors including cognitive impairment and sensory impairment. Additional documentation was submitted as an element of the response including a dignity of risk assessment, behaviour support plan and incident documentation.

The approved provider asserts that in relation to a recent incident of possible smoking inside the service, that there was no evidence the consumer was smoking inside their room other than the smell of cigarette smoke which may have entered the consumer’s room from outdoors. I note however that the incident form completed by staff states that the type of incident was ‘smoking in bedroom’ and that this occurred at 11.00pm at night; the consumer was noted to have a cigarette lighter in their possession at the time and a history of having done this previously is detailed in care related documentation.

The behaviour support plan submitted by the approved provider for the named consumer states that the consumer is confused, has been observed smoking internally and does not understand they cannot smoke inside. However, the incident form for the recent incident involving the consumer states that the consumer is to be reminded to smoke in a designated area.

The dignity of risk assessment submitted by the approved provider states that the consumer has been found smoking in their room and that the risk of fire damage is high. However, staff have allocated a ‘minor’ risk score on the incident form where it has been documented that the consumer was ‘smoking in room’.

Documentation submitted in the approved provider’s response does not demonstrate how the consumer’s safety is managed while they are smoking cigarettes with the dignity of risk assessment stating that after lighting the cigarette for the consumer, staff are to return within 10 minutes to ensure the cigarette has been extinguished.

With respect to exit seeking behaviours, the Assessment Team have brought forward information that the named consumer has been found outside the building on a number of occasions and this has been confirmed in the approved provider’s response. The Assessment Team state that incident forms relating to these behaviours were incomplete. I note too, that staff interviewed by the Assessment Team did not demonstrate a shared understanding of the risks associated with exit seeking behaviours and smoking cigarettes for this consumer.

The approved provider’s response states that additional actions have been taken to improve care and service delivery for this consumer, including additional education and training for staff.

However, I remain concerned that the approved provider’s response did not include information as to how the service was monitoring the consumer’s behaviour to ensure their ongoing safety, including for that period when they are smoking cigarettes given the consumer has a cognitive impairment and a sensory impairment. Strategies documented in incident forms to manage risks were inappropriate given the consumer’s cognitive status, and information documented in incident forms was incomplete and/or inaccurate.

Information brought forward by the Assessment Team relating to consumers entering other consumers’ rooms uninvited has been considered under other requirements.

I find this requirement is 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.*

### 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.*

### 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 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

Consumers said they felt safe living at the service and that they were encouraged to attend activities and maintain contact with those people who are close to them. Consumers and representatives provided examples of how they can visit to maintain relationships with their husband/wife or relative.

Most consumers said that staff support them to do things of interest to them and provided examples of activities they enjoyed including attending exercise groups. Consumers said they can do as little or as much as they want and said they have access to an activities calendar and receive daily reminders. Representatives of consumers residing in the memory support unit provided mixed feedback about the level of consumer engagement and activities offered in this part of the home. The approved provider in its response to the site audit report outlined a number of actions being taken to strengthen the activity/lifestyle program offered to consumers who reside in this area of the service.

Consumers were able to describe the services and supports available to them to support their emotional, spiritual and psychological well-being. Consumers and representatives advised that registered staff and care staff are supportive of consumers. Consumers provided examples of how staff support them including taking time to talk with them.

Consumers were generally satisfied with their ability to participate in the community both within and outside the service. Most said they are able to maintain relationships that are important to them. Some consumers provided examples of how staff assist them with telephoning families and using digital video conferencing software.

Consumers expressed satisfaction with catering and said they were satisfied with the variety, choice and size of meals.

Lifestyle staff said information about consumers’ interests is collected when a consumer moves into the service including their social interests and engagement with external community organisations.

Care staff said information about the consumer’s needs and preferences is communicated through handover, care plans, progress notes and one to one conversation. Staff were familiar with how to support consumers who are feeling low and said they have a chat with them or ask the consumer if they would like to go for a walk. Staff said they had access to sufficient equipment to meet the consumers’ lifestyle needs and could explain the processes relating to the safe use of equipment.

Catering staff could explain how consumers’ dietary preferences are identified and communicated and how the menu is planned and developed. They were observed to have a food safety program available to them and were conforming with food safety requirements including the use of personal protective equipment.

Lifestyle care plans and related documentation included information about the consumer’s religious background, preferences for emotional support and those people the consumer wants involved in their care. Where consumers are inclined to keep to themselves, documentation reflects this. Referrals to other service providers were reflected in documentation including for example, hairdressers and services to support consumers’ psychological well-being.

Dietary information included dietary needs and the consumer’s likes and dislikes and catering staff demonstrated a sound knowledge of consumers’ individual food requirements, allergies, likes, dislikes and foods that need to be avoided due to medical conditions.

The Quality Standard is assessed as compliant as seven of the seven specific requirements have been assessed as compliant.

## 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.*

Consumers reported they are encouraged to attend activities and that staff support them to do things of interest to them. Consumers provided feedback about some of the activities they attend, such as the exercise group and stated that they enjoy the group activity. An activities calendar provides consumers with information about planned activities and consumers said they also receive daily reminders for specific events. They said that they can do as little or as much as they want and that staff know their preferences.

The Assessment Team observed activities being held during the site audit in the general areas of the service including exercises, quizzes and word games. However, in the memory support unit, the Assessment Team observed that limited activities were offered to consumers during the site audit. Activities offered in this area were observed to be music and movies on the television and a number of consumers were observed sitting in front of the television in the same spot each day of the site audit.

Representative feedback for consumers residing in the memory support unit was mixed with some representatives interviewed by the Assessment Team raising concerns about lack of consumer engagement and lack of activities; representatives attributed this to staffing levels. Staffing levels have been considered further under Standard 7.

The approved provider in its response to the site audit report advised that a business case has been submitted to the organisation to increase leisure and lifestyle hours in the memory support unit across the weekend. Leisure and lifestyle hours are being adjusted to better cater to consumers’ needs including maximising consumer engagement in activities and providing one on one support.

The approved provider’s response included an activity participation chart for consumers in the memory support unit for a week in May 2022. Activities provided included pet therapy, one on one activities ( for example hand massage and manicures), physical games, gardening, board games, relaxation activities, television and music.

The approved provider has stated that a comprehensive audit of leisure and lifestyle programs was conducted across the organisation in June 2022 and recommendations have been submitted to the Board for further review and action. The service has commenced audits on activity charts to evaluate consumer engagement and interest in the current program that is offered and consumer preferences are being captured through a series of case conferences.

The approved provider included in its response a copy of the leisure program for the memory support unit for June 2022. The program was offered across seven days and included exercises, card games, ball games, art/craft, music therapy, pet therapy, memory games and puzzles.

I acknowledge that the approved provider has taken action to strengthen its performance under this requirement and am satisfied that the actions taken will promote consumer’s health, well-being and quality of life, particularly for those consumers residing in the memory support unit.

I find this requirement is compliant.

### Requirement 4(3)(b) Compliant

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

### Requirement 4(3)(c) Compliant

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

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

### Requirement 4(3)(d) Compliant

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

### Requirement 4(3)(e) Compliant

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

### Requirement 4(3)(f) Compliant

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

### Requirement 4(3)(g) Compliant

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

# STANDARD 5 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

Consumers and representatives generally expressed satisfaction with the service environment saying consumers felt as though they belong and that they were satisfied with cleaning and maintenance. While most consumers and representatives reported that consumers felt safe and comfortable some reported that consumers were negatively impacted by other consumers walking into their room uninvited.

The Assessment Team observed communal spaces for socialisation throughout the service including covered verandas outside and seating areas. The service was generally clean and well maintained and there were processes in place to ensure furniture, fittings and equipment was safe, clean and regularly maintained. Cleaning and maintenance schedules guided staff practice.

There were established processes for cleaning and maintenance and staff were familiar with how to identify hazards and report maintenance issues. Maintenance staff could explain how maintenance requests are risk assessed and prioritised.

Staff said they had access to sufficient equipment to support consumer care and service delivery including lifting equipment, wheelchairs and shower chairs.

The Assessment Team found that some areas of the service were not easy to understand and did not optimise consumers’ ability to function within the environment. Directional/landmark signage was limited, hallways and rooms were painted the same colour and patterned bed linen in the memory support unit tended to be the same for most consumers. While some consumers’ rooms were personalised, the Assessment Team found that most were generic in appearance. Further to this, feedback was received from some consumer representatives that consumers found it difficult to navigate their way throughout the service, particularly those consumers living with dementia.

The Quality Standard is assessed non-compliant as one of the three specific requirements have been assessed as non-compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Non-compliant

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

The Assessment Team brought forward information that the service’s environment did not consistently support consumers’ ability to interact and function within the environment.

Consumer representatives said consumers living with dementia, find it difficult to navigate their way through the service and that consumers often wander into other consumers’ rooms. Some consumers reported having to lock their doors to prevent other consumers from entering uninvited. The Assessment Team observed consumers that appeared to be lost and confused requiring directional assistance; consumers were also observed entering other consumers’ rooms.

Management staff reported that the memory support unit is ‘bland’ and does not provide a stimulating homely environment for consumers. They said that a renovation project is planned for the memory support unit and this includes the purchasing of new furniture.

The Assessment Team observed that hallways and consumers’ rooms were painted the same colour with a small identifying number located above the door. Some doors were identified with consumers’ names and some had pictures on them. In the memory support unit, consumers’ bed linen was found to generally be the same and the Assessment Team observed the rooms to appear generic. Landmark signage (dining/lounge and bathroom/toilets) was not visible however the service commenced addressing this on the last day of the site audit.

The approved provider in its response to the site audit report asserts that the service provides a homely environment and that this was confirmed by the Assessment Team who reported that consumers felt a sense of belonging at the service and were safe and comfortable.

The approved provider states that a community project to beautify the service was initiated in late 2020 and while fundraising continued, the project was delayed due to external factors. This project has been recommenced and expressions of interest have been sent to consumers and representatives and contact has been made with various groups including local artists and photographers.

The approved provider has included actions to support consumers within their environment in the plan for continuous improvement and I note that workshops have been conducted that include the care of consumers living with dementia and how to support consumers to navigate through their environment; these were held in May 2022 and June 2022. I note too that the plan for continuous improvement includes an action item in January 2022 arising from consumer feedback that found all wings looked the same and that this made it difficult for consumers to find their way. While planned actions included the possible use of decals being placed in each wing and/or renaming of wings, the plan for continuous improvement did not demonstrate if these actions have been completed or any outcomes resulting from this initiative.

Quality improvement logs that were initiated in response to the Assessment Team’s findings were submitted as an element of the approved provider’s response and included improvement opportunities to support consumers’ wayfinding skills. Strategies included using visual cues, simple signage and conducting workshops to support the care of consumers living with dementia. Information held in consumers’ social profiles and ‘key to me’ documentation has been used to inform strategies to individualise consumers’ rooms. I note the quality improvement logs state there have been improved outcomes for consumers following the implementation of these initiatives and that staff report consumers are not entering other consumers’ rooms as often as they were previously.

The approved provider asserts that consumers have a right to lock their doors and I accept this. However, I do not accept that consumers should have to lock their doors to prevent other consumers from entering their rooms uninvited.

I have considered information in the site audit report and in the approved provider’s response. I have given weight to the Assessment Team’s observations and to feedback from consumers, representatives and management staff. I note that concerns about the environment and its impact on consumers’ function were raised over six months ago and were reflected in the service’s plan for continuous improvement however these concerns persist.

For the reasons detailed, I find this requirement is non-compliant.

### Requirement 5(3)(b) Compliant

*The service environment:*

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

Most consumers and representatives spoke positively about the service environment and said that they feel safe and comfortable and that the service is clean and well maintained.

Maintenance staff described processes to ensure high risk maintenance issues are prioritised. They said the service is checked daily for hazards such as trip hazards, a maintenance schedule is in place that includes scheduled inspections and reporting occurs.

Cleaning staff demonstrated an understanding of cleaning processes including daily cleaning of communal areas and consumers’ rooms with a deep cleaning of consumers’ rooms occurring weekly.

Staff were familiar with the processes relating to maintenance requests and hazard identification including high risk or urgent issues.

The Assessment Team observed communal spaces for socialisation throughout the service including covered external verandas and outdoor seating. The service environment was found to be clean and well maintained

However, the Assessment Team raised concerns about consumers’ ability to move freely within the service environment, particularly for those consumers who reside in the memory support unit. The Assessment Team brought forward information that on the first day of the site audit these consumers had no access to outdoor areas as doors leading to these areas had been locked, that risk assessments had not been completed and that informed consent for environmental restraint had not been sought. Management staff advised the Assessment Team that the doors were locked due to recent rain resulting in an unsafe environment for consumers.

The approved provider in its response to the site audit report refutes the Assessment Team’s findings and asserts that temporary closure of the courtyard attached to the memory support unit was implemented to remove risk. The response included additional evidence to demonstrate that consultation, risk assessments and risk minimisation strategies were implemented to manage the risk associated with the extended period of wet weather and external trip hazards related to mould build up. The approved provider states that action had been taken to remove mould and that plans were in place to apply further treatments as soon as the service experienced consecutive days of dry weather. Further to this the approved provider stated that all consumers had a dignity of risk form in place for environmental restraint due to being in a secured unit.

Following the site audit, the approved provider liaised with the authorised decision makers for all consumers residing in the memory support unit and all were happy with the temporary closure of the courtyard as a means of preventing falls and related injuries.

The approved provider acknowledges that signage was not in place communicating temporary closure of the doors however this has been rectified.

Evidence submitted by the approved provider in relation to this includes:

* the risk assessment completed in May 2022 for the courtyard attached to the memory support unit identifying the area as hazardous following unprecedented wet weather and detailing risk minimisation strategies
* policies relating to restrictive practice
* dignity of risk forms completed for a named consumer and a dignity of risk audit
* notification of required maintenance that included pressure cleaning of external courtyard and pathways
* improvement logs, and
* the service’s plan for continuous improvement that includes actions to address safety concerns in the environment.

The Assessment Team brought forward feedback from one consumer that other consumers entering their room makes them feel unsafe and two representatives advised their relatives have to lock their doors due to consumers entering their rooms uninvited. I have considered this information under other requirements in Standard 5.

I am satisfied that that the service is safe, clean, well maintained and comfortable and that consumers can generally move freely both indoors and outdoors. I accept that the actions taken by the approved provider to lock the doors leading to the external courtyard were a temporary solution to remove risk and note that all authorised decision makers for consumers in the area affected supported the decision.

I find this requirement is compliant.

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

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

# STANDARD 6 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

Consumers and representatives said they would feel comfortable and safe in raising a concern about care and services and are confident that action would be taken. Consumers provided examples of complaints they had made about isolated aspects of care and service delivery including communication processes, a missed appointment with allied health and meal preferences. Consumers said that their concerns had been addressed and they were satisfied with the outcome.

Governance systems include policies and processes for capturing feedback and complaints from consumers and their representatives. The organisation has written material about how to make complaints, advocacy services and language services and this information is promoted by the service and is made available to consumers. Feedback is analysed, actioned and trended to inform continuous improvement initiatives.

Management staff said the service encourages feedback from consumers and this includes sending new consumers a consumer experience survey to complete. They provided examples of how the service had responded to recent complaints received.

Staff demonstrated an understanding of complaints processes and open disclosure and most staff could describe the language and advocacy services available if needed. Staff said they ask consumers on a daily basis if they are okay and if there is anything they can do to help them. They could describe how they would support a consumer who has cognitive impairment or difficulty communicating and said if necessary they would escalate the consumer’s concern to the registered nurse or management staff.

The Assessment Team found that information about complaints and feedback mechanisms is included in the consumer information handbook, complaints resolution policies and feedback forms. The Assessment Team reviewed the feedback and complaints register and associated consumer survey reports and found that consumers’ complaints and feedback are actioned in a timely manner and that open disclosure processes are applied.

The Assessment Team observed information about advocacy groups, language services and external complaints mechanisms displayed on noticeboards throughout the service.

The Quality Standard is assessed as compliant as four of the four specific requirements have been assessed as compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

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

### Requirement 6(3)(b) Compliant

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

### Requirement 6(3)(c) Compliant

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

### Requirement 6(3)(d) Compliant

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

# 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

Consumers and representatives provided positive feedback about staff being kind and caring.

The Assessment Team observed interactions between staff and consumers and found that staff were respectful, kind and friendly. Staff sought permission to enter consumers’ rooms and asked them about their preferences before assisting them.

There are processes to support staff knowledge and skills that include toolbox sessions, mandatory education and competencies.

The organisation has policies, procedures and documents relevant to this standard that guide staff including a code of conduct and employee handbook.

However, while consumers and representatives said staff were kind and respectful, concerns were raised about the sufficiency of staffing and how it impacted consumers negatively.

Management staff stated that consumers had provided feedback that they had experienced delays in staff attending to their requests for assistance and staff reported difficulties in meeting consumers’ activities of daily living.

While the organisation has processes to support the assessment, monitoring and review of the workforce, these have not been consistently effective.

The Quality Standard is assessed as non-compliant as two of the five specific requirements have been assessed as non-compliant.

## 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.*

Consumers and representatives expressed dissatisfaction with staffing sufficiency and staff response times. They reported that staff are rushed and are not always able to meet consumers’ care needs and preferences.

Consumers who need assistance with mobility said that they have experienced delays waiting for staff to assist them when they want to move to another part of the service or go to the toilet. One consumer reported experiencing incontinence as a result of waiting long periods of time for staff to assist them.

Consumers’ representatives provided examples of how insufficient staffing impacted the consumer. One representative said their relative has been left sitting on the toilet for extended periods of time. Three representatives said there was a lack of staff in the memory support unit. They raised concerns about the quality of care provided in relation to personal care (toileting, oral care and continence care), consumer engagement, activities and behaviour management.

Care staff said that insufficient staffing impacted their ability to deliver care and services particularly in relation to mobility, toileting, behaviour management and their ability to spend time talking with consumers or calming those who required additional support. Staff provided an example of a consumer who was faecally incontinent as a result of having to wait for staff.

The care manager said that feedback about long waits and call bell response times has been an ongoing issue for consumers.

Call bell response times reviewed by the Assessment Team identified a number of response times that exceeded the service’s policy of a 15-20 minute response time. There was no evidence provided of actions taken by management in response to delays in response times. However, during the site audit the plan for continuous improvement was reviewed and included processes that included an audit to track call bell responses that fall outside established parameters.

The complaints register was reviewed by the Assessment Team and included a recent complaint relating to staff delays. The complainant raised concerns about staffing and an episode of incontinence stating there was no point asking for staff assistance as ‘it takes two hours’ for them to respond.

The approved provider in its response to the site audit report, refutes the Assessment Team’s findings and asserts that the service has a consistent staffing level, adequate staff ratios and an appropriate staff skill mix.

The approved provider’s response includes evidence of proposals to increase staffing hours in the memory support unit. A request has been sent to the Board requesting additional hours for leisure and lifestyle and an additional six care staff hours per day. The proposals state that there are consumers in the memory support unit with complex behaviours that require supervision. They state that there were 30 falls in the memory support unit in May and that staff find it difficult to supervise the consumers. Further, the proposals say that increased staffing would assist supervision, increase consumer engagement, reduce the number of falls, assist with activities of daily living and provide staff with more time to spend with consumers.

The approved provider refers to the site audit report where the Assessment Team have reported that staff respond to changes in a consumer’s condition in a timely manner, that end of life care maximises the consumer’s comfort and dignity and that staff generally are aware of consumers’ needs. I accept this. However, this does not negate consumer and representative feedback that inadequate staffing levels have impacted consumers’ care and services resulting in them experiencing episodes of incontinence and delays in staff assisting them with mobility and other aspects of daily living. I note too that the plan for continuous improvement includes actions to investigate call bell response times that fall outside organisational policy and that weekly reporting will occur.

I acknowledge that the approved provider is taking action to increase staffing and improve monitoring and supervision of staff in responding to consumers’ requests for assistance. However, I have given weight to consumer and representative feedback and am satisfied that the delivery of safe, quality care has been compromised by staffing levels.

I find this requirement is non-compliant.

### Requirement 7(3)(b) Compliant

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

### Requirement 7(3)(c) Compliant

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

Consumers, representatives and staff provided mixed feedback about workforce knowledge that included concerns about staff capacity to manage complex behaviours and deliver other aspects of care. Consumer and representative feedback about staff inability to effectively support consumers with complex behaviours was often associated with staffing sufficiency.

The general manager said the service has documented core competencies for each role and that the onboarding process ensures all staff have the relevant qualifications and skills in line with the core competencies. Staff qualifications and competency documentation is obtained at recruitment and during the orientation process. Staff have position descriptions across all roles at the service and these were observed to be in documentation associated with the orientation program.

There is a system for checking qualification registrations and criminal record checks; registers to track these are maintained.

Information brought forward in the site audit report under other requirements demonstrates that staff generally demonstrated competency in their role. For example;

* staff knew how to support consumers with communication barriers
* staff were familiar with strategies to promote privacy and confidentiality of consumers’ personal information
* staff were familiar with their responsibilities in relation to assessment and care planning
* aspects of clinical care including pain management and wound care were generally completed in accordance with the organisation’s guidelines
* care staff and nursing staff could describe how they care for consumers approaching end of life
* staff were able to demonstrate their understanding of how to minimise infection related risks; and the service demonstrated preparedness for a potential outbreak of COVID-19, and
* staff were familiar with strategies to support consumers emotional and psychological well-being.

The approved provider’s response to the site audit report asserts that the organisation has an onboarding system that ensures staff registrations are current. Care staff have qualifications in aged care and some are completing a Bachelor of Nursing.

Evidence of ongoing education and training was provided that included the staff education planner, toolbox sessions and education attendance registers. Topics addressed included restrictive practice, antimicrobial stewardship, falls prevention, COVID-19, pressure injury prevention and various competency assessments (donning/doffing, hand hygiene, respiratory assessment, vital observations and neurological observations).

While feedback was received about staff’s inability to support consumers with complex behaviours, I have considered this further under Requirement 7(3)(a) and note that since the site audit additional education and training relating to the care of consumers with dementia has been provided.

The approved provider’s response included the 2021 Consumer Satisfaction Survey that demonstrated high levels of satisfaction with staff knowledge and skills. Additionally, the plan for continuous improvement includes a focus on staff knowledge and has been revised to address deficiencies brought forward by the Assessment Team.

I am satisfied that while the Assessment Team identified some deficits in knowledge, particularly in relation to behaviour management, at the time of the site audit, that this has been addressed by actions taken by the approved provider. I am satisfied that staff have been provided with ongoing opportunities to build on their knowledge and skills.

I find this requirement is compliant.

### Requirement 7(3)(d) Compliant

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

The Assessment Team brought forward information that the service has a planned training schedule however stated that education sessions are not well attended and that training has not been effective in ensuring staff have the skills to manage complex behaviours.

Some consumer representatives said that staff required further training in the care of consumers with dementia and in managing complex behaviours. This feedback had also been brought forward under other requirements with representatives asserting that insufficient staffing levels impacted staff’s ability to support consumers with complex behaviours. I have considered this information under requirement 7(3)(a).

The general manager advised that there are mandatory training/education sessions and competencies that staff must undertake annually and that there is an associated assessment component. The general manager advised that some staff were not up to date with their mandatory training and that this had been in part, attributable to external factors.

Management stated that training needs are identified through incident reporting, clinical meetings, case conferences, clinical indicators, staff performance, quality audits and other monitoring activities. Management said toolbox talks are conducted and provided examples of sessions that have been conducted or are currently being planned; these included nutrition and hydration and pressure injury prevention, recognising and responding to clinical deterioration and food safety.

Management staff provided examples of how the education program is designed to address staff knowledge deficits. For example, toolbox talks were arranged after the quality officer completed a quality check and identified that continence charting was not being consistently completed and additional training in dementia care was organised to promote staff knowledge and understanding in supporting consumers with complex behaviours when a need was identified.

The service has recently recruited a new education co-ordinator and I note that improvements are being made to the quality management training system with the implementation of a new electronic training system.

The approved provider in its response to the site audit report refuted the Assessment Team's findings. The approved provider stated that the organisation is currently transitioning to a new learning platform and that as a result of this process there were some discrepancies in information provided to the Assessment Team and provided an example of where this had occurred. I accept this.

The approved provider’s response included the 2021 Consumer Satisfaction Survey that demonstrated high levels of satisfaction with staff knowledge and skills. Additionally, the plan for continuous improvement includes a focus on staff knowledge, education and training and has been revised to address deficiencies brought forward by the Assessment Team.

The approved provider in its response submitted the education calendar for January-June 2022. Topics addressed include governance, risk management, Serious Incident Response Scheme, antimicrobial stewardship, clinical care (falls management, pain management, skin care and wound management), dementia care and behavioural support plans, COVID-19 planning/preparedness and minimising restrictive practice. Education attendance registers (including mandatory education) were provided demonstrating that staff participation at education including fire safety, infection control, Serious Incident Response Scheme, Aged Care Quality Standards, restrictive practice, manual handling, COVID-19 and personal protective equipment is monitored.

The education program provided at the service has included a focus on dementia specific training with a 4.5 hour workshop provided to staff. The education includes complex case reviews, defining and explaining behaviours that require support, strategies to provide the individual with a sense of security and interacting therapeutically. All staff in the memory support unit had completed training by 22 June 2022 with ongoing participation by staff from across the service.

Management demonstrated how they identify what training the workforce will need in line with new or changed consumer needs. There is evidence demonstrating that training has been provided and that there are strategies to monitor attendance. I am satisfied that the workforce is supported to deliver care and services in accordance with the Aged Care Quality Standards.

I find this requirement is 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 found that the organisational processes in place to monitor and review staff performance were not consistently effective and that there were staff without a current performance plan and a significant number of staff overdue for a performance review.

Management staff described the performance review process at the service stating that there is an annual performance review and that it includes a discussion about any improvements to performance, training needs and completion of mandatory training.

Some staff could recall participating in a performance review and provided examples of positive feedback they had received and areas where they could strengthen their performance; they said that the organisation had provided them with resources to build on their existing skill set. While some staff could recall having completed a performance review, management staff stated that some performance reviews were outstanding.

The approved provider in its response to the site audit report refutes the Assessment Team’s findings and asserts that there are processes in place to review performance. The approved provider stated that external factors have contributed to the need to reschedule performance reviews and that there are currently no performance management issues. Further, the approved provider advised that in the previous 12 months, performance management had occurred for one staff member when underperformance was identified.

While I accept that external factors have impacted the scheduling and completion of performance appraisals, the approved provider has not advised how this will be addressed going forward. Additionally, the approved provider has not outlined how the service has monitored and reviewed the performance of the workforce during this period given that it advised in its response that approximately 30% of staff are overdue for a performance review.

I am satisfied that the service has not consistently assessed and monitored the performance of its workforce.

I find this requirement 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

Consumers said that the organisation is well run, that they are well informed and that they feel comfortable providing feedback and raising issues. Various forums support consumer engagement including bi-monthly consumer meetings, surveys, lifestyle and food focus groups and complaints mechanisms.

A five year strategic plan is in place and reporting mechanisms provide information to the Board in relation to clinical governance and management.

The service was generally able to demonstrate effective governance systems in relation to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints. However, workforce governance arrangements were not effective and the organisation had not ensured that sufficient staff were available to provide safe quality care and services.

The Assessment Team brought forward some deficiencies in relation to risk management and clinical governance. This information was considered together with information brought forward under other requirements and the approved provider’s response to the site audit report.

The organisation is able to demonstrate risk management processes that include policies and procedures, incident reporting mechanisms, regular management meetings and reporting to the Board. A high impact high prevalence risk register is maintained.

A clinical governance framework is in place and includes policies relating to antimicrobial stewardship, restrictive practice and open disclosure.

The Quality Standard is assessed as non-compliant as one of the five specific requirements have been assessed as non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

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

### Requirement 8(3)(b) Compliant

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

Consumers generally spoke highly about the management of the service and reported that it was well run. Consumers were generally satisfied with their level of engagement and felt that they could provide feedback on care and services. Consumers were satisfied that staff respected their identity, culture and diversity and staff could describe how they ensure consumers feel respected.

The organisation has a strategic plan and monitors the performance of the service through the self-assessment process, internal audits, a clinical governance committee, the plan for continuous improvement, feedback and complaints mechanisms, surveys and monthly reporting to the Board.

The approved provider’s response to the site audit report included evidence that the organisation monitors risk including through the clinical governance and management monthly report. The response included the Board meeting schedule whereby regular meetings are scheduled at an executive level to review the performance of the service.

The Assessment Team brought forward deficiencies in a number of requirements. The approved provider responded to the information in the site audit report; additional information was provided and the service’s plan for continuous improvement was revised.

I find this requirement 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.*

The service was generally able to demonstrate effective governance systems in relation to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints. However, workforce governance arrangements were not effective and the organisation had not ensured that sufficient staff were available to provide safe quality care and services.

Consumers and representatives provided feedback that consumers had experienced negative outcomes as a result of staffing insufficiency. They provided examples of how consumers had experienced delays with staff providing assistance with consumers’ activities of daily living including for example, assistance with mobilising and assistance with toileting.

Care staff said that insufficient staffing impacted their ability to deliver care and services particularly in relation to mobility, toileting and behaviour management.

Management staff reported that there had been feedback from consumers about delays in staff attending to their needs and the site audit report includes information that the plan for continuous improvement was revised during the site audit to include monitoring of call bell response times.

The approved provider’s response to the site audit report includes evidence of a proposal to increase leisure and lifestyle staffing hours and care staff hours. The proposals state that this increase in hours will improve care delivery, increase consumer engagement and will improve consumer supervision.

I am satisfied that governance processes relating to workforce management were not effective and while action is being taken these actions are yet to be fully implemented and evaluated for effectiveness.

I find this requirement is non-compliant.

### Requirement 8(3)(d) Compliant

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

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

The Assessment Team brought forward information that the organisation has not demonstrated effective risk management systems are in place particularly for those consumers with complex behavioural needs.

The site audit report includes information that a risk register is monitored by the quality team and at an organisational level. Staff reported that policies relating to abuse and neglect had been discussed with them and that this was included as an element of their annual training.

Information brought forward in the site audit report under other requirements demonstrates that care planning processes generally include information about risks and the service collects data relating to medication incidents and clinical indicators including falls and pressure injuries.

The approved provider in its response to the site audit report refutes the Assessment Team’s findings. The approved provider outlines actions that are taken to manage risk including:

* weekly clinical review meetings attended by senior clinical staff, allied health, care staff, lifestyle staff and if possible, the nurse practitioner
* regular management meetings
* monthly reporting to the general manager
* incident and accident reporting with an incident register maintained.

The response includes evidence of clinical governance meetings, a clinical governance action register and an incident management policy. Topics addressed through the clinical governance meetings include quality indicators, incident data and the Serious Incident Response Scheme. I note that when an increasing trend is identified this is further explored. Additionally, the approved provider included the high impact high prevalence risk register demonstrating how risks are identified and rated. I note that the clinical governance action register includes an action item for the organisation in general to improve incident reporting; strategies to support this are detailed.

The approved provider submitted information about relevant education provided to staff that is specific to their roles. Education included elder abuse and the Serious Incident Response Scheme.

While the Assessment Team brought forward concerns about behavioural incidents, I have considered this under other standards including Standard 3. I note that the approved provider has accessed specialised support from the Local Health District and that several workshops on dementia care have been conducted. Additionally, the approved provider has increased staffing in the memory support unit to support consumer engagement and increase supervision of consumers and assistance with behavioural management.

I am satisfied that the service has taken action to address risk associated with the management of complex behaviours and that there are systems and processes in place to manage risk more broadly.

I find this requirement is compliant.

### Requirement 8(3)(e) Compliant

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

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

The Assessment Team brought forward information that the organisation has a clinical governance framework that outlines the responsibilities, structures and expectations regarding the provision of quality clinical are to ensure the safety, health and well-being of consumers.

The Assessment Team reviewed documentation and policies relating to clinical governance including policies related to antimicrobial stewardship, minimising the use of restraint and open disclosure.

Management provided examples of how these policies influenced care and service delivery and said that improvements had been made in relation to the electronic training system, antimicrobial stewardship and reporting requirements associated with infection control and clinical governance.

However, the Assessment Team raised concerns that ineffective clinical governance contributed to poor practice in relation to the use of environmental restraint, primarily in the memory support unit and insufficient staffing impacting care delivery and clinical oversight.

I have considered the information in the site audit report about consumers’ inability to access the courtyard in the memory support together with the information in the approved provider’s response. The approved provider states that consumers in this area had an existing authorisation for environmental restraint in place due to residing in the memory support unit and that courtyard access was temporarily restricted due to unsafe weather conditions; I accept this and have addressed this more fully under Standard 5.

The site audit report includes information about lack of staff and impact on care and service delivery, and I have considered this information under Requirement 7(3)(a) and Requirement 8(3)(c).

The approved provider in its response to the site audit report refutes the Assessment Team’s findings and states that a clinical governance framework is in place that ensures training and education is maintained that is compliant with best practice and is tailored and specific to consumers’ needs. Evidence submitted indicates that clinical aspects of care and service delivery are addressed in the education program.

Registered nurses have regular training days and a nurse practitioner is available for consultation and review of consumers’ care needs.

The organisation has partnerships with external health service providers including dementia specialists and advisory services , Local Health District services, Older Person’s Mental Health services and a palliative care nurse practitioner. Half day dementia specific training workshops have been held for staff with most staff from the memory support unit already completing this and ongoing training opportunities occurring.

Clinical governance meeting minutes and action register were submitted as an element of the response and demonstrate further that there are systems to monitor clinical care and that these are reviewed at an organisational level.

Consumers generally reported that they were engaged in care and service delivery and could make decisions about their care including making complaints and that this had resulted in improvements.

I am satisfied that an effective clinical governance framework is in place and find this requirement is 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.

* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:
  + is best practice; and
  + is tailored to their needs; and
  + optimises their health and well-being.
* Effective management of high impact or high prevalence risks associated with the care of each consumer.
* The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.
* 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.
* Regular assessment, monitoring and review of the performance of each member of the workforce.
* Effective organisation wide governance systems are to be established with a particular focus on workforce governance.