Performance

Report

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| Name of service: | Serene Residential Care Services |
| Service address: | 1 Myzantha Street LOCKLEYS SA 5032 |
| Commission ID: | 6820 |
| Approved provider: | Blu Dawn Pty Ltd |
| Activity type: | Review Audit |
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| Performance report date: | 3 February 2023 |

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

**This performance report**

This performance report for Serene Residential Care Services (**the service**) has been prepared by M Glenn, 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 Review Audit; the Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* the provider’s response to the Assessment Team’s report received 4 January 2023.

# Assessment summary

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

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

# Areas for improvement

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

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

* + Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences and risks to consumers’ health and well-being are identified and management strategies developed to enable staff to provide quality care and services.
  + Where consumers’ are subject to restrictive practices, ensure Behaviour support plans are developed and include all required information in line with legislative requirements.
  + Ensure assessment and planning processes are based on ongoing partnership with the consumer and others the consumer wishes involved.
  + Ensure outcomes of assessment and planning are effectively communicated with consumers and/or representatives.
  + Ensure care plans are discussed with and made available to consumers and/or representatives.
  + Ensure consumer care plans are reviewed for effectiveness and/or updated both in electronic and hard-copy versions to ensure they are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
  + Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
  + Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
  + Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

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

* + Ensure staff have the skills and knowledge to:
* provide personal and or clinical/care and services to consumers in line with their assessed needs and preferences and that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to management of restrictive practices and diabetes;
* provide appropriate care relating to management of behaviours, wounds and pain;
* identify types of restrictive practice and use restrictive practices in line with legislative requirements, including as a last resort;
* identify consumers at end of life and deliver care in line with their needs, goals and preferences to ensure comfort is maximised and dignity preserved; and
* use personal protective equipment to prevent and control the spread of infection and implement practices to promote appropriate antibiotic use.
  + Ensure information relating to consumers’ personal and clinical care needs is documented and effectively communicated to others, including to consumers and/or representatives.
  + Ensure policies, procedures and guidelines in relation to best practice care, management of high impact or high prevalence clinical risks, end of life care, infection control and antimicrobial stewardship are effectively communicated and understood by staff.
  + Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care, management of high impact or high prevalence clinical risks, end of life care, infection control and antimicrobial stewardship.
  + Review the Outbreak management plan to ensure it is up-to-date and reflective of current practice and related guidelines.

**Standard 5 Requirements (3)(b) and (3)(c)**

* + Ensure consumers are able to move freely to outdoor areas.
  + Ensure monitoring processes to ensure the service environment is safe, clean and well maintained are regularly undertaken.
  + Ensure processes to monitor the safety, maintenance and suitability of equipment are regularly undertaken.

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

* + Ensure feedback and complaints are captured and appropriate action is taken in response, including liaising with the complainant.
  + Ensure feedback and complaints are documented, including actions taken and follow-up with the complainant to ensure satisfaction is achieved.
  + Review processes to ensure all feedback and complaints are captured to enable emerging trends and improvement opportunities to be identified.

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

* + Ensure staff competency, skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
  + Ensure staff are provided appropriate training to address the deficiencies identified in six of the eight of the Quality Standards.
  + Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken.
  + Ensure completion of mandatory training components is monitored.

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

* + Review processes relating to how consumers are supported and engaged in the development, delivery and evaluation of care and services.
  + To ensure the governing body is aware of and accountable for the delivery of care and services, review communication and reporting processes from the service to the Board and vice versa.
  + Review the organisation’s governance systems in relation to information management, continuous improvement, workforce governance, feedback and complaints and regulatory compliance.
  + Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks, responding to abuse and neglect and managing and preventing incidents.
  + Review the organisation’s clinical governance framework in relation to antimicrobial stewardship and minimising use of restrictive practices.
  + Review the organisation’s clinical governance framework in relation to the non-compliance identified in Standard 3 Personal care and clinical care.

# 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 were satisfied staff treat consumers with dignity and respect and value their identity, diversity and culture when delivering care and services. Lifestyle assessments included information relating to consumers’ social details, including their support network, significant events they wish to recognise and their past and present interests and how staff can support these needs. However, two examples of written language in documentation sampled was not respectful of the consumer’s culture and diversity. Management said they would provide a reminder to staff of the use of appropriate language. Staff were familiar with consumers’ backgrounds, needs and preferences and were observed treating consumers in a respectful manner.

Consumers from a range of cultural backgrounds were satisfied with the service’s approach to their culture. Care files demonstrated consumers are invited to discuss any cultural associations they may have and how the service supports these associations. Staff provided specific examples of delivering care and services in a way that is respectful of consumers’ ethnicity and culture. There are processes to support each consumer to exercise choice and independence, including making decisions about their own care and the way care and services are delivered. Decisions regarding family, friends, carers or others involved in consumers’ care, and making connections with others were documented in assessments and care plans.

Where consumers chose to partake in activities which include an element of risk, assessments are undertaken and discussions with consumers and their families about mitigating the risks to ensure their safety are undertaken. However, the Risk activity/Restraint assessment does not include an area to document discussions with consumers and representatives regarding possible consequences of risky lifestyle choices. This has been considered in my finding for Requirement (2)(a) in Standard 2 Ongoing assessment and planning with consumers. Staff described risk mitigation strategies for individual consumers and consumers confirmed they are supported to do the things they wish to do even where risk is involved.

Information provided to consumers is communicated clearly and is easily understood. Information is provided through a range of avenues, including emails, noticeboards, meeting forums and one-to-one visits. Consumers were happy with the information provided to them and indicated staff were very good at verbally communicating information. On entry, information regarding how personal details will be stored and managed and how the service seeks consent for the release of information is provided to consumers, and staff are informed of their responsibilities relating to privacy and use of consumers’ personal information on induction.

Based on the Assessment Team’s report, I find all Requirements in 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. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-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. | Non-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. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as all five of the specific Requirements have been assessed as non-compliant. The Assessment Team recommended all five Requirements in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied the service demonstrated assessments that consider all risks to consumers’ health and well-being, are completed when a consumer first enters the service. The Assessment Team’s report provided the following evidence relevant to my finding:

* + A Behaviour support plan was not in place for Consumer A to assist and guide staff in the management of behaviours, including the use of chemical and mechanical restraint. Staff were unable to describe strategies used prior to administration of as required psychotropic medication or when undertaking a practice to prevent the consumer from getting out of bed.
  + Three care and clinical staff said all consumers at high risk of falls, even those who are mobile, have beds placed at the lowest position as a safety precaution.
  + For three sampled consumers, Complex health assessments or diabetes care plans had not been completed to assist in management diabetes, including actions to be taken when blood glucose levels were not within acceptable ranges. For one of the three consumers, directives were not documented to guide staff in administration of sliding scale Insulin.
  + Risks associated with activities Consumer B chooses to partake were not consistently identified and planned to minimise any impact. Consumer B has been assessed as having compromised dexterity, however, the Risk activity/Restraint assessment dated August 2022 does not identify risk mitigation strategies and/or the consequences and possible outcomes of undertaking the activities.
  + The document does not confirm Consumer B has been informed of the consequences of the risks associated with the activities due to compromised dexterity, and only states the consumer is aware of risks and the actions.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report, as well as supporting documentation and actions taken in response. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Consumer A entered the service two weeks prior to the Review audit. It is usual practice for an interim care plan to be established immediately for staff to be aware of how to cover a consumers’ immediate clinical needs for safety. A Behaviour management needs care plan was provided.
  + Behaviour management needs care plans for three named mobile consumers, to demonstrate at the time of the Review Audit, these were and are in place. A Potential risk/Injury care plan, undated, for one named consumer indicating use of a low low bed.
  + A Diabetes care plan, undated, for Consumer A which the provider indicates was initiated in November 2022.
  + Diabetes management training has been conducted with staff.
  + Staff have attempted to discuss risks and mitigation strategies with Consumer B.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, assessment and planning processes did not effectively inform the delivery of safe and effective care and services.

In coming to my finding, I have considered management, clinical and care staff have not demonstrated an understanding of their legislative responsibilities in line with the *Quality of Care Principles 2014* in relation to assessment and planning processes relating to use of restrictive practices. Behaviour management needs care plans, included in the provider’s response for four named consumers, do not identify use of restrictive practices nor do they include any information to guide staff in the use of restrictive practices, such as when it is to be used, how long it is to be used for, associated risks and mitigation strategies in line with legislative requirements.

In relation to diabetes management, I acknowledge the provider’s response. However, I have placed weight on evidence presented in the Assessment Team’s report. While the provider’s response asserts a Diabetes management plan was in place for Consumer A prior to the Review Audit, the document provided is not dated. The provider also acknowledges one consumer’s Diabetes care plan was not updated to reflect the change to sliding scale Insulin. Insulin for this consumer was found not to have been administered in line the Medical officer’s directives.

In relation to Consumer B, I have considered that while management and staff indicated, and documentation demonstrated, an activity the consumer chooses to partake had been identified and a Risk assessment completed, the consumer’s compromised dexterity had not been considered through the assessment process. Additionally, the assessment does not identify sufficient and/or any risk mitigation strategies, consequences or possible outcomes of undertaking the activities nor that Consumer B has been consulted in relation to the risk assessment process. While one risk mitigation strategy was documented relating to one of the activities, staff and management stated the consumer did not use or implement this strategy. There was no indication further strategies to mitigate risks had been considered and/or implemented.

As such, I find the inconsistencies in assessment and planning have the potential to impact on the effective delivery of care and services, particularly where staff delivering care are not familiar with consumers’ care and service needs.

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

**Requirement (3)(b)**

The Assessment Team were not satisfied care plans consistently identify and address consumers’ current needs, goals and preferences. The Assessment Team’s report provided the following evidence relevant to my finding:

* + Care plans for three consumers did not include goals of care which is not in line with the service’s assessment procedure.
  + Consumer A’s Urinary care plan stated, ‘refer to the pad folder’. No toileting schedule or any additional information in relation to continence management was documented.
  + An end-of life care plan was not completed for Consumer C in line with the organisation’s process.
  + Consumer D’s palliative care plan included wishes relating to music therapy. Care and clinical staff were unable to describe what type of music the consumer would like to listen to during this phase.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report, as well as supporting documentation and actions taken in response. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Consulting with IT staff relating to input of goals information, with nursing staff to review and include goals at all reviews.
  + A Urinary continence management plan for Consumer A which the provider’s response asserts it was created in November 2022.
  + In relation to Consumer C, acknowledge to always try and get this information as soon a practically possible.
  + The Site manager and Lifestyle therapist liaise regarding palliative care tone, including suitable music. Lifestyle staff can discuss with family/representatives what music they prefer.

I acknowledge the provider’s response. However, this Requirement expects that services do everything they reasonably can to plan care and services that centre on consumers’ goals, needs and preferences. As such, I find at the time of the Review Audit, the service did not demonstrate assessment and planning identified and addressed consumers’ current needs, goals and preferences.

In coming to my finding, I have considered goals of care were not included in three care plans sampled. I find this has not ensured things that are important to consumers’ have been identified to enable a tailored approach to care to be implemented.

For consumer C, who was identified as requiring comfort and dignity care on return from hospital in August 2022, an end of life care plan was not developed, in line with the organisation’s process. Additionally, while Consumer D’s palliative care plan specifically identified the consumer’s wishes for music therapy, the type of music the consumer enjoys was not identified.

As such, I find the evidence demonstrates care plans are not individualised and tailored to guide staff to provide care and services which are in line with each consumer’s needs and preferences and planned around what is important to them. For consumers receiving end of life care, this has the potential for consumers to not have the end of life experience they would have wanted.

In relation to Consumer A, I have considered the provider’s response demonstrating a Urinary continence management plan was in place at the time of the Review Audit. However, management strategies on the care plan are limited. I would encourage the service to review information included in care plans to ensure it provides sufficient guidance for staff to deliver consumers’ care and services, in line with their assessed needs and preferences.

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

**Requirement (3)(c)**

The Assessment Team were not satisfied assessment and planning is currently based on ongoing partnership with the consumer and others the consumer wishes to be involved in the assessment, planning and review of their care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* + The service’s care planning process requires all consumers and/or representatives to be consulted in relation to review of assessments and care plans. Care plan evaluations for three consumers did not demonstrate any consultation.
  + Two representatives remembered being asked questions in relation to the care and services when consumers entered the service, however, had not been contacted about any reviews to the assessments.
  + There was no evidence indicating Consumer D’s December 2022 care plan evaluation had been discussed with their representative despite a decline in the consumer’s health since the last review in August 2022.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report as well as supporting documentation. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, examples of consultation with three consumers and/or representatives. The provider also indicated there are lots of regular consultations relating to care planning for those representatives that would like to be involved.

I acknowledge the provider’s response, including supporting documentation to demonstrate for three consumers, care consultations had occurred. However, on balance, I find at the time of the Review Audit, assessment and planning processes were not consistently based on ongoing partnership with the consumer and/or representative. In coming to my finding, I have considered feedback from representatives indicating while they recalled being asked questions relating to consumers’ care on entry, they had not been contacted on an ongoing basis in relation to review of care needs or assessments. I have also considered there is no evidence to demonstrate a care plan evaluation for Consumer D, who has had a decline in health, had been undertaken in consultation with the representative. As such, I find this has not ensured consumers are supported and encouraged to make decisions about the care and services they receive and the way they are delivered.

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

**Requirement (3)(d)**

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

* + Representatives and consumers stated they are not informed when assessments are undertaken or the outcome nor have they seen a copy of the care plan. One representative asked what a care plan was and another indicated while they have requested to see the care plan, staff have told them it is managed electronically and they do not need to see it.
  + Paper-based care plans, used by care staff to guide care, are not current and do not include consumers’ current needs. Staff were unable to provide strategies for management of Consumer A’s behaviour or how often Consumer D is required to be assisted with repositioning.
  + Assessments and care plans are not accurate or reflective of consumers’ care needs, goals and preferences, including in relation to pain management for Consumer F and use of non-pharmacological behaviour management strategies for Consumer A.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report as well as supporting documentation. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Representatives have different levels of needs in terms of being involved in assessment and care planning processes. Through the example of weekly meetings with one representative, we believe we have demonstrated that we can identify representatives that would and would not like to be involved.
  + The care plan is a document all representatives can view and be involved with and all staff will be reminded of this.
  + If the care plan is updated electronically, a paper based care plan is printed.
  + A Pain assessment/management plan for one consumer to demonstrate reference to pain related to a viral infection is noted.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, outcomes of assessments and planning were not effectively communicated to the consumer and documented in a care plan that was readily available to the consumer.

I acknowledge the provider’s response indicating representatives have different levels of needs in terms of being involved in assessment and care planning processes. However, I have considered the Consumer outcome for Standard 2 which states, ‘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’. I have considered feedback provided by representatives and consumers indicating the outcomes of assessment and planning had not been effectively communicated to them and they not had not sighted care plans. As such, I find this does not demonstrate consumers and/or representatives have been involved in discussions relating to consumers’ care or has it enabled them to have an understanding and ownership of the care plan.

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

**Requirement (3)(e)**

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

* + Fifteen of 37 care plans were over 4 months since last reviewed.
  + Consumer F’s care plan was last reviewed in November 2022, including review of pain management, which indicated the consumer had pain related to a viral infection requiring additional pain medication. The pain assessment was not completed to include this information to assist and guide staff.
  + Consumer D’s care plan was last reviewed in August 2022, however, the dated report created states December 2022. The pain management evaluation does not refer to pain associated with pressure wounds.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report as well as supporting documentation. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Care plan reviews are four monthly, however, comes up on the electronic reminder system on the third month to allow one month for the review.
  + A Pain assessment/management plan for Consumer F to demonstrate information had been included relating to the viral infection.
  + The pain management evaluation in August 2022 does not refer to pain as Consumer D did not have pressure injuries at this time.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the service did not ensure care and services are regularly reviewed for effectiveness or in response to changes in consumers’ care and service needs.

I acknowledge commentary in the provider’s response clarifying the electronic reminder system for care plan review dates. However, I have considered care plans have not been regularly reviewed in line with the service’s process of four monthly, with 15 of 37 records sampled noted to be overdue the four month timeframe. As such, I find that this has not ensured care plans are up-to-date or that care and services are being delivered in line with consumers’ current needs and preferences.

In relation to Consumer F, progress notes between October and December 2022 indicate the consumer is experiencing ongoing pain. A pain care plan last reviewed in November 2022 did not capture pain associated with the wound or resolved viral infection, only indicating ‘regular analgesia and PRN (as required) for (viral infection)’. There is no information relating to presentation of pain related to the viral infection or wound nor specific management strategies documented. I have considered that information relating to pain management, specifically for the viral infection and wound, is not sufficient to ensure the consumer’s pain management needs are effectively met.

In relation to Consumer D, while the provider asserts the consumer did not have pressure injuries when the pain management evaluation was last undertaken in August 2022, a wound evaluation completed in November 2022 indicates the consumer is experiencing pain relating to a pressure injury. While a pain assessment was commenced in November 2022 to review pain management, progress notes indicate this was not completed. There is no indication pain management strategies have been reviewed or new strategies implemented since increased pain relating to the pressure injury was identified.

As such, I find these practices have not ensured care plans are up-to-date and care or that services are being delivered in line with consumers’ current needs and preferences.

For the reasons detailed above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers non-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. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as five of the seven specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(g) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied each consumer gets safe and effective personal care and/or clinical care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to management of medications, restraint, and diabetes. The Assessment Team’s report provided the following evidence relevant to my finding:

* + Medication was not consistently observed to be administered in line with best practice guidelines with medications observed being left with consumers with no supervision to ensure they were taken.
  + Staff stated all consumers at high risk of falls have their beds placed at the lowest level for safety. There was no evidence informed consent had been obtained for the use of low-low beds for mobile consumers or other falls management strategies being trialled prior to use of low-low beds.
  + Consumers were unable to access any outdoor areas, with all doors locked. Staff confirmed no doors are unlocked around the service environment. Management stated no consumers have an environmental restraint nor had this been identified as a form of restraint.
  + Two consumers did not have blood glucose levels monitored and recorded in line with Medical officer directives. Consumer E’s insulin was not administered in line with the medication order, and while blood glucose levels were noted to be decreasing on one day in December 2022, regular Insulin continued to be administered with no follow-up monitoring to ensure blood glucose levels were within range.

The provider’s response did not dispute the Assessment Team’s findings. The response included commentary to address some of the deficits highlighted by the Assessment Team, actions taken in response and supporting documentation. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified, specifically in relation to medication management. The provider’s response included, but was not limited to:

* + Clinical staff responsible for medication administration were reminded of their responsibilities and counselled and medication competencies were completed with all clinical staff.
  + Acknowledge there are areas to improve in restrictive practices. Restrictive practice training was conducted; informed consent obtained for all mobile consumers who can use outdoor areas; and use of bed tags to guide staff on appropriate resting bed height for relevant consumers has been commenced.
  + An observation chart to demonstrate Consumer E’s blood glucose level was re-tested following administration of Insulin, however, acknowledge Insulin was not administered in line with the medication order on two occasions. Blood glucose monitoring competencies will be completed by all clinical staff by early January 2023.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the service had not ensured each consumer was provided safe and effective clinical care that was best practice and optimised their health and well-being, specifically in relation to restrictive practices, diabetes and medications.

For consumers identified as being at high risk of falls, I find the use of a restrictive practice was not in line with best practice care or with legislative requirements. Additionally, consumers had not been identified as being subject to environmental restraint. For both the mechanical and environmental restrictive practices, authorisation for use had not been obtained and there was no evidence to demonstrate alternative strategies, specifically in relation to use of low beds, had been trialled or the effectiveness of the strategy noted. As such, I find this does not demonstrate that care has been tailored and based on assessment of consumers’ needs, goals and preferences.

In relation to diabetes management, I find Medical officer directives were not consistently followed to ensure effective management of blood glucose levels. I have also considered observations demonstrating medications were not consistently administered in line with best practice processes. I acknowledge actions taken by the provider in response to deficits identified in relation to management of diabetes and medications, however, I would encourage the provider to continue to actively monitor staff practices as they relate to these aspects of clinical care.

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

**Requirement (3)(b)**

The Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of consumers, specifically in relation to behaviours, wounds and pain. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* + Consumer A is prescribed two as required psychotropic medications. A Behaviour support plan is not in place to guide staff in the use of the chemical restraint and the consumer does not have the diagnoses the medications are indicated for. One of the medications was administered on eight occasions over a 13 day period in November and December 2022. Progress notes do not evidence non-pharmacological interventions trialled prior to administration, with one entry stating the medication was ‘first line’.
  + Staff said Consumer A displays a behaviour up to 20 times per night, however, this was only documented on three occasions for a two-week sampled period. Staff described a management strategy which consisted of implementing a mechanical restraint, however, there was no documented evidence that informed consent had been obtained for the use of the restrictive practice. Staff did not recognise the strategy as a form or restraint, citing this is for the consumer’s safety. In the three days prior to the Review Audit, Consumer A had two incidents resulting in injuries, however, the restrictive practice was not ceased nor strategies implemented to minimise associated risk.

Consumer D

* + A wound treatment plan for pressure injury 1 commenced in October 2022 does not detail repositioning requirements. Over a 20 day period between November and December 2022, the wound was only attended on eight occasions.
  + A wound treatment plan for pressure injury 2 commenced in August 2022. However, the chart relates to wounds on two separate limbs. Sixty-two days post identification, the wound was noted to have deteriorated. At this time, a wound chart was commenced solely for pressure injury 2.
  + A wound treatment plan for pressure injury 3, identified in August 2022, relates to wounds on two separate limbs, resulting in the inability to determine what wound care was applied.
  + Daily repositioning charts for a 15 day period between November and December 2022 showed Consumer D is not being attended to in line with their needs. On day one of the Review Audit, Consumer D was observed in bed in the same position.
  + Three staff said Consumer D is in significant pain when wound care is attended. This was supported by a wound evaluation in November 2022 which stated the consumer pulled away and showed signs of pain when attending to a wound. While the Medical officer indicated pain is managed with analgesic, an as required narcotic analgesic was prescribed for use prior to dressing changes, however, this has not been administered. A review of pain management was not undertaken until a week after the wound evaluation notation stating wound pain is managed with analgesia. Two staff stated the consumer will often refuse to have wound dressings changed, as they often experience pain when the wound dressings are attended.

Consumer F

* + Photographs of a wound taken in March 2022 showed a significant increase in size. A wound treatment evaluation indicated a referral to a wound clinic was initiated in April 2022, however, management confirmed this was not followed through and did not occur.
  + The wound appearance was not consistently documented on wound charting, with notations indicating ‘dressing done’ and treatments were not undertaken in line with treatment record directives between April and November 2022. Directives relating to a change in frequency of wound treatments following a hospital review in November 2022 were not followed.
  + The consumer was not repositioned, in line with wound treatment plan directives, over a 15 day period in November and December 2022.
  + Four staff said Consumer F experiences ongoing pain due to the wound and when wound care is attended, it causes the consumer a great deal of pain. Analgesia is offered if requested by the consumer.
  + Documentation shows that while a viral infection identified in November 2022 has resolved, the consumer is experiencing ongoing pain as a result.
  + Progress notes between October and December 2022 demonstrated the consumer experienced ongoing pain. A pain care plan last reviewed in November 2022 did not capture pain associated with the wound or resolved infection.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report, supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Provided training to staff in relation to management of restrictive practices, behaviour, pressure injury monitoring, wounds and pain.
  + For named consumers, initiated referrals General practitioners and/or behaviour management specialists and developed Behaviour support plans which include interventions and strategies.
  + Created a generic behaviour chart to capture all individualised behaviours.
  + Undertaken a thorough pain assessment for Consumer F and initiated a referral to the General practitioner resulting in a change in pain medication.

I acknowledge the provider’s response. In coming to my finding, I have considered that this Requirement expects that services effectively manage high impact or high prevalence risks associated with the care of each consumer. That is, each individual consumer should expect to have high impact or high prevalence risks associated with their care effectively managed. Based on the Assessment Team’s report, I find this did not occur for the three consumers highlighted, specifically in relation to management of behaviours, wounds and pain.

In relation to Consumer A, I have considered restrictive practices, both mechanical and chemical, used to manage the consumer’s behaviours have not been used as a last resort. Progress notes for a 13 day period in November and December 2022 did not evidence a trial of non-pharmacological interventions prior to use of a psychotropic medication and staff had not recognised a strategy to manage a behaviour as a restrictive practice. A Behaviour support plan to guide use the restrictive practices had not been developed and despite two incidents over a three day period, both resulting in injuries, use of the mechanical restrictive practice was not reviewed, potentially placing the consumer’s safety at risk.

In relation to Consumers D and F, I have considered staff practices have not ensured wounds are effectively monitored or assessed to enable wound progression to be tracked or that wound deterioration is effectively identified and actioned. For Consumer D, pressure injuries 2 and 3 were documented on the same wound chart making it difficult to determine which treatments were applied to each wound. I have considered that this practice has not ensured the progress of each wound was effectively monitored. A stand-alone wound treatment plan was not commenced for pressure injury 2 until it had deteriorated. For Consumer F, while a referral to a wound clinic had been initiated in April 2022 in response to a significant increase in the size of a wound, this referral did not occur and there was no indication this had been followed-up. Wound appearance had not been consistently documented or treatments undertaken in line with directives. Additionally, for both consumers, wound treatments had not been consistently undertaken in line with treatment timeframes. As such, considering the nature of the wounds described for both consumers, there should be an expectation that wounds are monitored at each treatment, including consideration of wound appearance. Such practices would ensure wound progression is monitored, wound deterioration is identified in a timely manner and actions taken accordingly.

In relation to Consumers D and F, I have also considered charting sampled demonstrated the consumers were not provided pressure area care in line with their assessed needs, placing them at further risk of skin integrity issues, including pressure injuries. For Consumer D, lack of pressure area care was also supported through observations made by the Assessment Team where, on one day of the Review Audit, the consumer remained in the same position in bed.

I have also placed weight on feedback provided by staff indicating pain is not effectively managed for both Consumers D and F. Staff identified both consumers experience pain when wound treatments are attended. While Consumer D has been prescribed a narcotic analgesic for use prior to wound dressing changes, the medication has not been administered. For Consumer F, progress notes between October and December 2022 indicate the consumer is experiencing ongoing pain relating to a wound and a viral infection, however, management strategies included in care planning do not specifically relate to the pain being experienced.

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

**Requirement (3)(c)**

The Assessment Team were not satisfied the service effectively identified a consumer's palliative care needs and maximised their comfort when nearing the end of their life. The Assessment Team’s report provided the following evidence relevant to my finding:

* + Consumer C returned to the service from hospital for comfort and dignity care. Progress notes do not demonstrate end-of-life care was commenced and assessment undertaken to guide staff in relation to the consumer’s goals, needs and preferences during the end of life phase. Progress notes do not show comfort care was provided, such as repositioning, oral intake or mouth care during the consumer’s last five days of life.
  + The representative stated they were disappointed with the care on Consumer C’s return (from hospital). The representative stated they never saw staff change the consumer’s position, cream was not applied to excoriated skin unless they hunted down a nurse and requested it and staff just were not able to deliver the care the consumer needed and needed prompting all the time.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report and supporting documentation. The provider’s response included, but was not limited to, discussing Consumer C’s past care and representative’s concerns with nursing and care staff with a reminder of areas of concerns and how to reduce likelihood of reoccurrence; and conducted end of life pathway training with all nursing staff.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the needs, goals and preferences of consumers, specifically Consumer C, nearing the end of life had not been recognised and addressed to ensure their comfort was maximised and dignity preserved. Despite returning from hospital for comfort and dignity care, an end of life pathway was not commenced or appropriate assessments undertaken, in line with the organisation’s procedure, to ensure the personal and clinical care delivered was appropriate, and in line with the consumer’s needs and preferences. Additionally, progress notes did not demonstrate the care provided to Consumer C to ensure their comfort was maximised. Representative feedback indicated they were disappointed with the care provided to Consumer C on return from hospital.

For the reasons detailed above, I find Requirement (3)(c) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(e)**

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

* + Representatives stated language barriers are a real concern as staff often have English as a second language and cannot communicate with a lot of the consumers. One representative stated they are at the service every day to provide care to the consumer as they are worried if they are not there, the consumer will not receive the care they need.
  + Care staff stated they are provided information during handover and can look at consumers’ care plans, however, paper-based care plans used by staff are not accurate of consumers’ current needs and services required.
  + Consumers’ clinical health needs are not effectively monitored and documented to assist and guide the Medical officer of changes that may be required. For example, pain monitoring is not undertaken or captured within progress notes to allow the Medical officer to review consumers’ pain levels and change medication as required.

The provider’s response included commentary to address evidence presented in the Assessment Team’s report as well as actions taken in response to deficits highlighted. The provider’s response included, but was not limited to, staff have been working with the representative to identify care needs; staff have access to electronic care plans; a new monthly statistics of clinical indicators, education and staff development, quality continuous improvement and legislative updates will be provided to all staff and directors monthly; and staff have been provided training in relation to pain management documentation and referral.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, information about consumers’ condition, needs and preferences was not effectively documented and communicated. In coming to my finding, I have considered feedback from representatives, indicating communication is difficult, particularly with staff who have English as a second language and that a consumer may not receive the care they need if the representative is not at the service every day.

I acknowledge the provider’s response indicating staff have access to electronic care plans. However, staff refer to hardcopy care plans. Evidence highlighted in Requirements (3)(a), (3)(b) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers indicates information contained in hardcopy care plans was either not congruent with electronic versions, up-to-date or reflective of consumers’ current care needs and preferences nor included sufficient information relating to management strategies to guide staff. As such, I have considered the workforce does not consistently have access to accurate information to enable coordination and delivery of safe and effective personal and/or clinical care or have sufficient understanding of consumers’ conditions to provide and coordinate care.

For the reasons detailed above, I find Requirement (3)(e) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(g)**

The Assessment Team were not satisfied the service demonstrated standard precautions to prevent and control infections, including strategies to manage COVID-19 infections or infections and antibiotic usage were effectively monitored. The Assessment Team’s report provided the following evidence relevant to my finding:

* + The service has one Infection prevention control (IPC) lead, however, could not demonstrate what happens when they are on leave or off-site.
  + Throughout the Review Audit, staff were observed not wearing face masks correctly and attending to consumers’ clinical care needs consumers' needs without gloves.
  + The service was unable to provide the numbers of staff that had undertaken mandatory infection control training or how many staff were still required to undertake this training.
  + Minimal hand hygiene stations were observed throughout the service environment.
  + The Outbreak management plan has not been updated since August 2020, despite the service experiencing four COVID-19 outbreaks during 2022
  + The service was unable to demonstrate effective monitoring of infections, consumers prescribed antibiotics or that pathology testing is conducted prior to commencement of antibiotics.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report, supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, training provided to staff in relation to infection control, masks and antimicrobial stewardship; updated the Outbreak management plan policy and procedure; and increased hand sanitiser numbers around the service.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the service and staff did not demonstrate effective practices to minimise infection related risks or to promote appropriate antibiotic use to reduce the risk of antimicrobial resistance.

In relation to prevention and control of infection, staff were observed either not correctly wearing or not wearing at all personal protective equipment to assist in minimising spread of infection, and staff training in relation infection control was unable to be demonstrated. I have also considered that despite the service experiencing four COVID-19 outbreaks in 2022, there was no indication improvements in practice and process had been identified or initiated with the Outbreak management plan not being updated since August 2020.

In relation to practices to promote appropriate antibiotic use, I have considered that two clinical staff were unable to describe antimicrobial stewardship principles and stated they have not been provided training. Additionally, antibiotic sensitivity or susceptibility tests to identify the most appropriate course of treatment are not consistently undertaken. I find such practices are not in line with antimicrobial stewardship principles which assist to minimise the development and spread of antimicrobial resistance.

For the reasons detailed above, I find Requirement (3)(g) in Standard 3 Personal care and clinical care non-compliant.

In relation to Requirements (3)(d) and (3)(f), staff described actions they take where they identify a change in consumers’ condition, including escalation to clinical staff. In response to consumer change or deterioration, clinical staff undertake relevant assessments and, where required, initiate referrals to Medical officers or Allied health specialists. A care file sampled demonstrated prompt monitoring and review of a consumer’s condition following a fall and where a change in condition was identified, the consumer was transferred to hospital. Staff stated any changes to consumers’ care needs following referral are communicated to them and consumers confirmed they are referred to Medical officers and Allied health specialists, where required.

For the reasons detailed, I find Requirements (3)(d) and (3)(f) in Standard 3 Personal care and clinical care 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

Lifestyle care assessments included information about consumers’ background, past and current interests, religious/cultural practices and additional services to support the consumer. Information in relation cultural, spiritual and psychological preferences is also captured through assessment processes. However, care files did not consistently record consumer goals and where recorded, goals were written from the perspective of the staff member rather than the consumer. Staff described processes for ensuring consumers’ needs are met, particularly in relation to gaining assistance from appropriate cultural groups to meet individual needs. Consumers described ways staff support them when they feel low, including spending more time with them. Additionally, consumers said they are engaged in the activities program and are supported to attend cultural or religious activities and events. Consumers were observed participating in a range of activities in line with the monthly calendar.

Information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely are referrals are initiated. Care staff described how they access information relating to consumers’ needs and preferences and consumers said their condition, needs and preferences are known to staff.

All consumers were satisfied with meal choices and the quality and quantity of meals provided. Consumers’ dietary needs and preferences, including allergies, likes and dislikes are identified and documented in care plans and there are processes to ensure this information is available, including to catering staff. Staff were knowledgeable about consumers’ needs and preferences and described how they meet individual consumers’ dietary needs.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use, including maintenance processes. However, the Assessment Team observed some equipment was not well maintained which has been considered in my finding for Requirement (3)(c) in Standard 5 Organisation’s service environment.

Based on the Assessment Team’s report, I find all Requirements in 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as two of the three specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(b) and (3)(c) in Standard 5 Organisation’s service environment not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied the outdoor service environment is accessible, well maintained and comfortable and enables consumers to move freely from indoors to outdoors. The Assessment Team’s report provided the following evidence relevant to my finding:

* + During the Review Audit, three doors leading to an external courtyard were locked with the exception of day two when the manager asked staff to unlock one of the doors following feedback from the Assessment Team. Two representatives, one consumer and two staff said the only way consumers can get out is when staff supervise them.
  + The internal courtyard included gym equipment, large weeds and fluff all over the area from the laundry. Gym equipment and outdoor furniture was dirty, and dumbbells were observed on a window sill.
  + The Maintenance officer was observed attending to the area, including cutting branches off two palms which had low growing fronds with large spikes, on the third day of the visit following feedback from the Assessment Team.
  + Several strips of tape adhesive residue were noted on the floor in communal areas with dirt and debris stuck to the adhesive. Walls and skirting boards were scuffed with peeling paint.
  + An audit scheduled in relation to the service environment scheduled for July 2022 had not been completed.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report, supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, cleaned the central courtyard and relocated dumbbells; completed an environmental audit of the whole facility and implemented a corrective action plan which is ongoing; removed adhesive taped and cleaned the floors; and circulated a memorandum to staff relating to locking and unlocking doors leading to the internal courtyard.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the service environment was not safe, clean and well maintained, nor were consumers able to freely access outdoor areas.

It is an expectation of this Requirement that the service environment promotes free movement of consumers, including to outdoor areas. During the Review Audit, doors leading to the external courtyard were locked and consumers and representatives indicated the only way consumers can access this area is when staff supervise them. I have also considered the external courtyard area was not well maintained and placement of gym equipment and low growing palm fronds posed a potential risk to consumers. I acknowledge the actions taken by the provider to address the deficits identified, however, I have considered that these actions were only initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes, noting that a Service environment audit scheduled for July 2022 was not undertaken to ensure a safe, clean and well-maintained environment for consumers was maintained.

For the reasons detailed above, I find Requirement (3)(b) in Standard 5 Organisation’s service environment non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the equipment was safe and well maintained. The Assessment Team’s report provided the following evidence relevant to my finding:

* + An oxygen concentrator was overdue for service, another did not have test and tag notification with the maintenance record system not identifying individual concentrator units as being tested and tagged. An oxygen cylinder regulator had expired and two oxygen/suction units were found to have expired medical equipment.
  + Four chairs were in poor condition due to delamination of vinyl.
  + Monitoring audits for November and December 2022 did not include monitoring of expiry dates or test tagging of equipment.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report, supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, returning oxygen concentrators not in use to the supplier; replacing the oxygen cylinder regulator, replaced all oxygen/suction units and masks in both oxygen stations; conducted an audit on chairs and arranged for re-upholstering.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, equipment used in the provision of consumers’ care and services was not well maintained. I have considered that delamination of chairs used by consumers does not enable effective cleaning of this equipment between use and poor maintenance and monitoring of oxygen equipment does not ensure this equipment is fit for purpose when it is required. I have also considered that the service’s own reporting and monitoring processes have not been effective as the deficits highlighted have not been identified through these processes.

For the reasons detailed above, I find Requirement (3)(c) in Standard 5 Organisation’s service environment non-compliant.

In relation to Requirement (3)(a), the service environment was observed to be calm and easy to navigate. Consumer bedrooms were personalised and shared rooms included use of privacy curtains. Consumers were observed spending much of their day in the communal lounge area or their bedrooms. Two consumers said they feel at home in the service environment and expressed it was important to them to add ‘personal touches’ to their bedrooms.

For the reasons detailed, I find Requirement (3)(a) in 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as two of the four specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied the service demonstrated appropriate action has been taken in response to complaints and feedback. The Assessment Team’s report provided the following evidence relevant to my finding:

* + A feedback log has not been maintained since 2021. Feedback data provided was limited to only feedback forms which included three complaints received within the last six months in relation to care and services. Management stated most complaints can be resolved easily with more complex complaints generally managed verbally and through email correspondence.
  + The Commission received a complaint in October 2022 relating to care provided to a consumer. Review of the consumer’s condition by the Assessment Team identified continuing issues with management of wounds and pain. Management stated issues identified through the Commission’s review were being discussed, with additional training provided through a staff meeting on 8 December 2022, however, could not demonstrate appropriate action was taken to address these deficiencies in a timely manner or ensure safe and effective care was being provided to the consumer prior to the training taking place.
  + A representative said they had ongoing concerns about clinical staff competency, the adequacy of staffing numbers and the lifestyle program. The representative said while they feel supported to discuss concerns with management and meets with them weekly, they do not believe appropriate action, with lasting effect occurs.
  + Management provided examples of email correspondence in relation to complaints received by the representative, including a complaint about the lifestyle program dated September 2022. In response, management stated they would undertake a survey; evidence was not provided to show this had occurred. There was no evidence to demonstrate additional actions taken in response to the lifestyle program activities.
  + Consumer progress notes and incident reports did not demonstrate an apology had been provided when things go wrong, with only notification that the family had been notified recorded.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report, as well as actions taken in response. A Plan for continuous improvement was also included outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, providing training to staff in relation to psychotropic use and open disclosure and email correspondence dated December 2022 to demonstrate the complaint with the Commission is closed. The response also indicated the lifestyle team seek regular feedback from consumers during meetings and through surveys about what activities they like to have in the calendar.

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

In coming to my finding, I have considered that appropriate follow up and action of complaints is not consistently undertaken. While the provider asserts a complaint lodged with the Commission in October 2022 was closed two weeks following the Review Audit, review of the consumer’s condition identified continuing issues with management of wounds and pain. I have also considered actions taken to address the issues raised in the complaint were not undertaken in a timely manner; staff were provided training relating to issues raised 52 days later. Additionally, I have also considered feedback from one representative indicating they do not believe appropriate action with lasting effects is taken in response to concerns raised. Actions identified, such as a survey, to address a concern raised by the representative in relation to the lifestyle program were not demonstrated to have been undertaken and evidence of the representative’s complaints, actions taken and appropriate follow up to ensure the complaint had been actioned to the representative’s satisfaction were not demonstrated.

I have also considered that the service does not maintain a Feedback log, and while easily resolved complaints are captured on feedback forms, more complex complaints are generally managed verbally and through email correspondence. I find that this practice does not enable effective monitoring of complaints data to occur or trends and improvements to care and service delivery to be identified.

While open disclosure processes were not evident in consumer progress notes and incident reports sampled, I placed weight on evidence highlighted in Standard 8 Organisational governance Requirement (3)(d). The evidence in this Requirement indicates consumers and representatives confirmed staff practice open disclosure when things go wrong, and the service is open and transparent and notifies representatives promptly when incidents occur. Staff understood open disclosure principles and provided examples where open disclosure had been practiced. I would encourage the service to review documentation processes relating to how open disclosure processes have been applied where things have gone wrong.

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

**Requirement (3)(d)**

The Assessment Team were not satisfied the service demonstrated how feedback and complaint data is effectively monitored, analysed and use to improve the quality of care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* + Management said complaints data is captured, trended and discussed at bi-monthly meetings. Meeting minutes sampled only included the number of complaints, compliments and suggestions captured each month with no information detailing the complaint made. November 2022 meeting minutes indicated one complaint was recorded in August, September and November 2022. However, the feedback folder included no complaints for August or November 2022 and one complaint, which was not captured, for the month of October 2022.
  + Only one continuous improvement initiative resulting from feedback and complaints was included on the Plan for continuous improvement.
  + Consumer and representative surveys, which are to be completed in line with the audit schedule, have not been undertaken in 2022 to identify opportunities for continuous improvement.
  + Bi-monthly consumer and representative meeting minutes for September and November 2022 did not record any feedback.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report, supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Acknowledged feedback was discussed but not trended for monitoring. All feedback has been entered onto the Feedback register which is now up-to-date.
  + Plan to conduct surveys early in 2023 with a new audit/survey schedule.
  + Bi-monthly consumer and representative meeting minutes are written by an independent Volunteer who captures all feedback.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the service did not demonstrate a best practice system to manage feedback and complaints were not reviewed and used to improve the quality of care and services.

In coming to my finding, I have considered that complaints data is not consistently captured, documented, monitored, analysed or trended to enable improvements to the quality of care and services to be identified and implemented. The Plan for continuous improvement only included one improvement initiative directly relating to a complaint. Additionally, no consumer surveys had been undertaken in 2022 and consumer meeting minutes did not include any feedback from consumers or representatives. As such, I find the service has not actively used avenues available to them to enable improvements to the quality of care and services to be identified.

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

In relation to Requirements (3)(a) and (3)(b), consumers and representatives are aware of mechanisms available to make a complaint, give feedback and suggestions, including through meeting forums, feedback forms and verbally, and generally felt supported by management to do so. Management maintain an open door policy and staff described how they support consumers to provide feedback, including through use of cue cards or seeking assistance from family, and where required, escalating to management.

Consumers and representatives have access to interpreters, advocacy and external complaint handling services. Staff said they liaise with family or friends when consumers have difficulty communicating and they will assist them in raising concerns or complaints, however, examples of this were not provided. Representatives are aware of external agencies who can assist them in raising their concerns and noticeboards were observed throughout the service detailing mechanisms for raising complaints and accessing language services. Advocacy and external complaint information is available in different languages and documented in the admission pack along with the consumer handbook.

For the reasons detailed, I find Requirements (3)(a) and (3)(b) in 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as three of the five specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied the service demonstrated effective monitoring of staff to ensure the workforce have the knowledge and skills to effectively perform in their roles, specifically in relation to management of behaviours, restrictive practices, incident reporting, wounds, pain, medications, infection control and use of students to complete tasks. The Assessment Team’s report provided the following evidence relevant to my finding:

* + Staff were not competent in assessment and management of pain, wounds, skin integrity, behaviours; reporting and documenting incidents, including those required to be reported under the Serious Incident Response Scheme (SIRS); or minimising infection related risks.
  + Care and clinical staff did not demonstrate understanding of regulatory obligations relating to restrictive practices, including the purpose of a Behaviour support plan and what constitutes a restrictive practice.
  + One care staff and three students said students are used to assist with care duties, especially during periods of unplanned leave. One clinical staff said students are told they are not to undertake duties without supervision by a qualified staff member, however, are not always aware of what happens on the floor.
  + Audits have not been conducted in line with the Audit schedule since April 2022. An audit for Standard 2 completed in April 2022 recorded a 100% compliance in relation to review of documentation, having not identified any issues in staff practice. Audits relating to Standard 8 Organisational governance have not been conducted since 2021.
  + The Plan for continuous improvement does not identify any areas for improvement in relation to clinical practice with the exception of deficiencies identified by the Commission following a complaint.

The provider’s response did not dispute the Assessment Team’s findings. The response included commentary addressing aspects of the Assessment Team’s report as well as actions taken in response and supporting documentation. A Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified was also provided. In the response, the provider acknowledged that internal audits did not identify some clinical gaps and indicated audits will be outsourced to an independent external auditor in 2023. Training has been provided to staff in relation to restrictive practices, infection control, pressure injuries, wound management, SIRS and incident management. The provider also asserted that no staff have been replaced by students, indicating students are observed in week one, are supervised in week two and have minimal supervision by the end of placement.

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

In coming to my finding, I have considered outcomes for consumers highlighted in Standard 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 Requirements (3)(a) and (3)(b), which have been found non-compliant, demonstrate consumers have not been provided care that is best practice, tailored to their needs or optimised their health and well-being or that high impact or high prevalence risks have been effectively managed. Deficits have been identified in provision of care relating to management of restrictive practices, diabetes, medications, pain, behaviours, wounds and skin integrity.

While I acknowledge the provider’s response indicating that no staff have been replaced by students, however, I have placed weight on feedback provided to the Assessment Team by staff, as well as students, indicating students are being used to assist with care duties, especially during periods of unplanned staff leave. As such, I find the service’s current processes have not been effective in monitoring the workforce to ensure staff are sufficiently competent and are working within their scope of practice.

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

**Requirement (3)(d)**

The Assessment Team were not satisfied the service demonstrated the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. The Assessment Team’s report provided the following evidence relevant to my finding:

* + Staff are expected to complete a suite of mandatory online training within three months of commencing employment and annually. The mandatory online training is not formally monitored to ensure staff are undertaking this training.
  + Clinical staff said they have not received training in relation to wound and pain management and management confirmed online mandatory training modules do not include these areas.
  + Training relating to restrictive practices and SIRS is not provided as part of the mandatory training suite, with face-to-face training offered once a year, generally in February. This training was last completed in March 2022 with 43 staff in attendance, however, all new staff who commenced employment subsequent to this training have not yet received training relating to these areas and will not until February 2023.
  + The online training suite did not include SIRS, however, management confirmed this is included in mandatory reporting training. However, completion of this training is not formally monitored to ensure completion. One of two clinical staff was not aware of SIRS or the reporting requirements.

The provider’s response did not dispute the Assessment Team’s findings. The response included commentary addressing aspects of the Assessment Team’s report as well as actions taken in response and supporting documentation. The provider’s response included, but was not limited to, new employees are directed to complete compulsory on line training within the first month with the Facility manager notified via email once the training has been successfully completed; and during orientation, training, including in relation to restrictive practices and SIRS is provided.

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

I have considered that the service has not ensured the workforce is supported to undertake training, learning and development opportunities to meet the requirements of their role. This was supported through feedback from clinical staff who indicated they have not received training in relation to wound and pain management and another who was not aware of SIRS reporting requirements. Deficits in relation management of wounds, pain and reporting of SIRS incidents have been identified with related Requirements found non-compliant.

The provider’s response included commentary and supporting documentation to demonstrate how the Facility manager is notified of completion of compulsory training for new employees. However, a formal process to monitor completion of mandatory training components for both new and existing employees was not demonstrated either during the Review Audit or through the provider’s response.

In coming to my finding, I have also relied upon evidence and outcomes in Standard 2 Ongoing assessment and planning with consumers indicating deficits relating to assessment, planning and review processes and Standard 3 Personal care and clinical care relating to management and monitoring of consumers’ personal and/or clinical care needs.

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

**Requirement (3)(e)**

The Assessment Team were not satisfied the service demonstrated understanding of the intent of this Requirement and undertakes regular assessment, monitoring and review of each member of the workforce. The Assessment Team’s report provided the following evidence relevant to my finding:

* + There is a Performance review and development procedure requiring performance reviews to be completed after the probationary period and every 2 years for all staff members. However, staff were not able to discuss the performance review process.
  + Management confirmed they have moved away from undertaking ‘performance appraisals’ and are trialling a ‘Training needs analysis form’ which has been sent to staff in lieu of a formal appraisal, detailing areas staff would like additional training.
  + Management stated they have not had to performance manage a staff member formally and where conversations have been had with staff about their performance, these have been informal conversations and not documented.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report. The provider’s response stated the performance appraisal form was replaced with the training needs analysis which is completed every second year and was completed for all employees in December 2020.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, ongoing monitoring of the performance of each member of the workforce was not demonstrated. In coming to my finding, I have considered the intent of the Requirement which expects the performance of all members of the workforce is to be regularly evaluated to identify, plan and support any training and development needs. While the provider asserts the training needs analysis has replaced the performance appraisal form, management stated this process will not necessarily prompt a review or discussion with individual staff about their performance, rather the form will detail additional areas of training staff would like.

I have also considered evidence to demonstrate ongoing monitoring, review and evaluation of staff performance was not demonstrated as deficits highlighted by the Assessment Team across six of the eight Quality Standards have not been identified by the service’s own monitoring processes.

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

In relation to Requirements (3)(a) and (3)(b), there are processes to ensure the skill mix of the workforce is considered in addition to staffing levels based on consumer acuity and staff feedback, with rosters reviewed weekly. Most staff indicated sufficient staff are rostered with efforts made to fill short notice leave utilising a casual staffing pool; agency staff are not used by the service. Staff said they sometimes feel rushed to perform all their duties, especially when all shifts aren’t filled, and when this occurs, students are often used in place of a qualified staff member and undertake some unsupervised tasks. The majority of consumers and representatives were generally satisfied with staffing levels stating consumers did not have to wait long for assistance.

All consumers and representatives were complimentary of staff describing them as kind, caring, respectful and valuing consumers’ culture. Consumer preferences and cultural needs are factored into rostering and care plans outline consumer preferences and cultural requirements to guide staff. Staff demonstrated familiarity of individual consumer needs and all said they feel comfortable raising concerns with management if they believed staff were treating consumers poorly.

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

Findings

The Quality Standard is assessed as non-compliant as all five of the specific Requirements have been assessed as non-compliant. The Assessment Team recommended all five Requirements in Standard 8 Organisational governance not met.

**Requirement (3)(a)**

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

* + Management described how consumers are primarily involved in improving care and services through resident meetings and surveys. Bi-monthly Resident meeting minutes showed minimal participation, suggestions and engagement from consumers. Surveys, which review care and services in line with the audit schedule and Standards, are overdue and have not been completed in 2022.
  + A Feedback register is not maintained. Management stated most feedback is received verbally or via email and is managed at the time of receipt. This does not allow trends and continuous improvement initiatives to be clearly identified.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report, as well as actions taken in response to some of the deficits identified. The provider’s response included, but was not limited to:

* + Consumers are involved in improving care and services and management seek frequent feedback for improvement through meetings and provided two examples.
  + Acknowledge feedback was discussed but not trended for monitoring. All feedback has been entered onto the Feedback register which is now up-to-date.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the organisation’s processes did not ensure consumers are effectively engaged in development, delivery and evaluation of care and services and are supported in that engagement.

Documentation sampled by the Assessment Team indicate consumers are not actively engaged in the development, delivery and evaluation of care and services. Meeting minutes included minimal input from consumers and surveys had not been completed at all in 2022 to enable the organisation to gauge consumers’ satisfaction and identify improvement opportunities with the care and services consumers receive. Additionally, complaints data is not consistently captured, documented, monitored, analysed or trended to enable improvements to the quality of care and services to be identified and implemented. As such, I find this has not ensured consumers’ experience and the quality of care and services provided has been considered in the development, delivery and evaluation of care and services.

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

**Requirement (3)(b)**

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

* + Written reports regarding care and services are not provided by the service to the governing body, with all information provided by phone, email or communication platforms. These communications are generally between the Facility manager and one of the Directors who has clinical experience, however, were unable to be demonstrated during the Review Audit.
  + The governing body said they visit the service one to two days per week and will meet with staff and the Facility manager and have access to the clinical management system should they wish to run reports or access pertinent information. The governing body stated they rely on the Facility manager to inform them when they have concerns relating to care and services and do not request written information.
  + Board meetings are held quarterly, however, have not been minuted since April 2021. April 2021 meeting minutes included information relating to finances, maintenance, workforce and a new call bell system, however, did not include any information relating to incidents or clinical care and services.
  + Management and staff confirmed they have not received information from the governing body in relation to the new Code of Conduct which took effect 1 December 2022 and were not able to describe its purpose or their responsibilities under the Code of Conduct.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report and supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, Directors have now started minuting meetings; implemented a new reporting system covering, but not limited to, incidents, hazards, infections, a range of clinical indicators, feedback, legislative updates and quality continuous improvement; and circulated a memorandum to staff relating to the Code of Conduct legislation update.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the organisation did not effectively demonstrate the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

In coming to my finding, I have considered that reporting processes from service management to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services. The governing body indicated they rely on the Facility manager to inform them when they have concerns relating to care and services and do not request written information. Additionally, while Board meetings are held quarterly, minutes have not been maintained since April 2021; minutes from April 2021 did not include any evidence of discussion relating to incidents or clinical care and services. As such, I find such practices do not ensure the governing body is aware of whether it is meeting what consumers, the workforce and others expect for safe, inclusive and quality care and services from the organisation.

I have also considered that the findings of non-compliance in relation to 22 Requirements across six of the eight Standards indicates the governing body may not sufficiently understand their responsibilities as they relate to monitoring and improving the performance of the organisation against the Quality Standards.

In relation to the Code of Conduct, I have considered the evidence in the Assessment Team’s report and the provider’s response in my finding for Requirement (3)(c) in this Standard.

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

**Requirement (3)(c)**

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

Information management

* + Paper-based care plans used by staff are not accurate with dates of review differing to that of electronic care plans.
  + Clinical staff confirmed they have access to policies and procedures in hardcopy, however, these have not been updated since 2019.
  + Incident reports were not completed for incidents which did not result in injury, contrary to policies and procedures. Incident reporting data does not capture all incidents to allow for accurate monitoring and recordkeeping.

Continuous Improvement

* + Quarterly meetings are scheduled to discuss continuous improvement initiatives and actions taken to address improvements listed on the Plan for continuous improvement. Only one meeting has been held in 2022.
  + Audits and consumer and representative surveys are overdue and have not been completed in line with the schedule for Standards 3 through to 8. Monitoring is also undertaken through progress note and incident report reviews, however, deficiencies identified by the Assessment Team highlighted in Standards 2 and 3 were not identified through these mechanisms.
  + Only one continuous improvement initiative is listed on the Plan for continuous improvement. No improvements have been self-identified. An organisational Plan for continuous improvement is not maintained.

Financial Governance

* + Regular financial monitoring at a Board level was not demonstrated, with no delegated financial authority for out of budget expenditure. Regular financial monitoring at a Board level was not demonstrated as Board meetings have not been minuted since April 2021. The Board stated financial reports are provided via email each month, however, the last email received was dated April 2022.

Workforce governance

* + Mandatory online training is not monitored to ensure completion.
  + Audit tools, used to monitor staff competency, have not been completed since April 2022. And while competency is also monitored through progress notes and incident data review, these processes failed to identify deficiencies in care and staff knowledge relating to restrictive practices and management of behaviours, wounds, pain and diabetes.
  + Staff performance is not being monitored and reviewed in line with policies and procedures.
  + Governance systems failed to identify and/or act on, provision of unsupervised care to consumers by care and nursing students.

Feedback and complaints

* + A Feedback log has not been maintained, in line with the service’s policies and procedures, since 2021.
  + Management stated complaint data is captured, trended and discussed at bi-monthly staff meeting minutes. Meeting minutes demonstrated only the number of complaints, compliments and suggestions are captured each month, with no information detailing the complaint made.
  + Reports relating to complaints are not provided to the governing. The Facility Manager would let the governing body know about notable complaints or they could review complaint data electronically.
  + Regulatory compliance
  + Management and the governing body did not demonstrate awareness of the Code of Conduct. Communications have not been distributed and staff sampled were not aware of the Code of Conduct and its purpose.
  + Management did not have the necessary knowledge of legislative changes to ensure requirements in relation to restrictive practice, Behaviour support plans and SIRS were met. Staff who commenced after March 2022 have not received training in relation to restrictive practices and while SIRS training is provided as part of the ‘mandatory reporting’ training, attendance is not monitored.

The provider’s response included commentary providing further context to the evidence outlined in the Assessment Team’s report as well as supporting documentation and actions taken in response. The provider’s response included, but was not limited to:

* + Printed care plans are reviewed every three months and an updated copy is printed annually or when significant changes occur. Policies and procedures were developed in May 2019 and are due for review in 2024. All up-to-date policies and procedures are available in several locations, accessible to staff.
  + Incident reports were not completed for physical behaviour from consumers to staff if it did not result in injury.
  + Consumers are involved in improving care and services and management seek frequent feedback for improvement through meetings. Examples of three improvements from consumer suggestions and an incident were provided. Acknowledge the internal audit did not identify some clinical gaps. Audits will be outsourced in 2023.
  + There is regular financial monitoring at Board level. Monthly reports are generated and show financial performance relative to a set budget both monthly and year to date. Financial delegations were described.
  + Annual mandatory training, including on SIRS, restrictive practice and infection control is conducted annually and is available on line and optional training, including pain, behaviour and wound management.
  + The new aged care Code of Conduct legislation update was briefed via a memorandum and sent to all staff.
  + The Feedback register is now up-to-date and all feedback is registered and trended based on the areas and discussed at meetings.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the service did not demonstrate effective organisational governance systems, specifically in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

In relation to information management, I find that information used by staff to guide provision of care and services was not up-to-date. While the provider asserts staff have access to electronic care plans, staff stated they use hard-copy care plans. Information in care plans sampled was either not congruent with electronic versions, up-to-date or reflective of consumers’ current care needs and preferences or did not include sufficient information relating to management strategies to guide staff with provision of consumers’ care and services. I have also considered that data, including in relation to feedback and complaints, infections and clinical incidents is not being effectively collected to enable accurate trending, analysis and reporting to occur or improvements in the provision of care and services to be identified at an individual, site or organisational level to occur.

I have considered that while a Plan for continuous improvement is maintained, only one improvement initiative was listed on the Plan. Audits and surveys have not been implemented in line with the service’s own schedule and other avenues to identify improvements, such trending and analysis of incidents and feedback and complaints have not been sufficiently conducted to enable improvement opportunities to be effectively identified. There was no indication the Plan included improvements across all eight Quality Standards or that improvements had been identified through a range of sources. I have also considered the findings of Non-compliance in relation to 22 Requirements across six of the eight Standards indicates deficiencies with the governance processes associated with continuous improvement.

In relation to workforce governance, I have considered that evidence provided in the Assessment Team’s report in relation to Standard 7 Requirements (3)(c), (3)(d) and (3)(e) demonstrate the organisation’s workforce governance systems are not effective. I find the organisation’s processes have not ensured the workforce competent, or supported to deliver safe and quality care and services to consumers. I have also considered deficits highlighted by the Assessment Team across six of the eight Quality Standards indicates the organisation’s processes to monitor and review the performance of each member of the workforce have not been effective.

While there are processes to monitor changes to aged care law to ensure regulatory obligations are met, I find these processes have not been effective. I have considered that use of restrictive practices, including chemical, mechanical and environmental restraint, have not been identified and/or implemented in line with legislative requirements, nor had Behaviour support plans and restraint authorisations for consumers subject to restrictive practices been completed. Additionally, a key legislative update had not been identified through the organisation’s processes, was not known by management or the governing body or information relating to the update provided to staff.

In relation to feedback and complaints, I have considered the finding of Non-compliance in relation to Standard 6 Feedback and complaints Requirements (3)(c) and (3)(d) indicates deficiencies with the governance processes associated with feedback and complaints. I find the organisation’s processes have not ensured appropriate actions are taken in response to feedback or feedback is consistently captured, reviewed and used to improve the quality of care and services.

I am satisfied the organisation has effective financial governance systems and processes to manage the finances and resources. The provider’s response outlined financial reporting and monitoring processes through the governing body and delegation and approval processes for out of budget spending.

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

**Requirement (3)(d)**

The Assessment Team were not satisfied the service demonstrated effective risk management systems and practices for the management of high impact or high prevalence risks, responding to abuse and neglect, and managing and preventing incidents. The Assessment Team’s report provided the following evidence relevant to my finding:

* + A risk register was not in use, in line with the organisation’s risk management framework. Management stated risks are identified and managed through assessment processes and discussed at relevant meetings. Additionally, consumer progress notes and incidents recorded in the electronic system are reviewed.
  + Meeting minutes included clinical indicators and incidents with total figures trended against prior months. There was no information regarding individual consumer risks.
  + Current risk management systems were not effective in managing and monitoring consumer risks and identifying deficits in care, including in relation to restrictive practices, wounds, pain and behaviours. Systems to provide protections and safeguards for consumers were not effective in identifying and responding to the neglect of Consumers A, D and F.
  + Audits have not been completed in line with the Audit schedule since April 2022.
  + Incidents are not consistently recorded in the incident management system. Management stated staff are only required to lodge an incident report when injury has occurred which is not in line with the service’s policy which states incidents are to be reported with or without injury.
  + Serious incidents relating to restrictive practices and wound management, had not been identified or reported in line with the organisation’s policy and/or regulatory requirements.
  + The governing body is not provided with reports or documented information relating to clinical indicators, with management stating this information is discussed verbally, with the governing body having access to the clinical management system and ability to run reports.

The provider’s response did not dispute the Assessment Team’s findings. The response included commentary to address aspects of the evidence presented in the Assessment Team’s report and actions taken in response. A Plan for continuous improvement was also provided which outlined planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, training has been provided and/or planned in relation to management of risk, behaviours, pressure injuries, wounds, incidents and SIRS; and three incidents relating to inappropriate use of restrictive practices have been reported under SIRS.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the organisation did not demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks, identifying abuse and neglect or managing and preventing incidents.

In coming to my finding, I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks, specifically in relation to restrictive practices, wounds, pain and behaviours as highlighted in Standard 3 Personal care and clinical care Requirements (3)(a) and (3)(b). While three consumers highlighted have been identified with high impact or high prevalence risks, these have not been effectively identified and/or monitored, to ensure timely identification, assessment and monitoring of risks to their health, safety and well-being. I have also considered that the organisation’s own monitoring processes have not identified deficits identified by the Assessment Team relating to management of high impact or high prevalence risks to consumers’ care.

In relation to identifying and responding to abuse and neglect, I have considered the service failed to identify and report incidents, specifically in relation to use of restrictive practices without consent, in line with their legislative responsibilities.

I have also considered that management and staff have not demonstrated an understanding and application of their own incident reporting and escalation processes. Not all consumer incidents had been documented, escalated or reported, with only incident reports being completed for incidents resulting in injury which is not in line with the service’s policy document. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement or risks to consumers’ health and well-being are minimised and/or eliminated.

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

**Requirement (3)(e)**

The Assessment Team were not satisfied the service demonstrated an effective organisational clinical governance framework to ensure consumers are receiving safe and quality care that meets best practice and legislative guidelines. The Assessment Team’s report provided the following evidence relevant to my finding:

* + The Clinical governance framework is limited to information relating to antimicrobial stewardship and antipsychotic medication minimisation. The framework does not include any information relating additional clinical governance systems or responsibilities of the governing body and/or leadership team.
  + Audits have not been completed in line with the Audit schedule since April 2022, with overdue audits, including for Standard 3 Personal care and clinical care and in relation to this Requirement.

Antimicrobial stewardship

* + Clinical indicator reports, and meeting minutes outline the number and type of infections recorded per month. The reports do not include the antimicrobial intervention, whether the organism has been identified or if the infection is new or ongoing. The effectiveness of the treatment or cause is not captured to allow for effective trending analysis.
  + Management said pathology is not routinely undertaken as this is at the Medical officer’s discretion. The related procedure indicates to ensure antimicrobials are only prescribed in line with therapeutic guidelines and where possible, use diagnostic tests to inform treatment decisions and ensure robust infection data collection and data analysis along with antimicrobial prescribing and usage and report to committees responsible for clinical governance.
  + Management confirmed a clinical governance committee is not in place and reports are not provided to the governing body. Policies and procedures have been provided by an external consultancy company.

Minimising use of restrictive practices

* + Three care and clinical staff, and two students, said all consumers at high risk of falls, including those who are mobile, have beds placed at the lowest position as a safety precaution.
  + A progress note dated August 2022 stated the Physiotherapist had identified staff were putting beds at the lowest setting for consumer who are mobile. Whilst this had been identified by the Physiotherapist as a restrictive practice, this was not monitored to ensure the practice was ceased or reported under SIRS.
  + Physiotherapy assessments show 21 of the 37 consumers can mobilise. All exits are locked, resulting in these consumers being subject to environmental restraint, however, informed consent for environmental restraint has not been obtained.
  + All consumers subject to restrictive practice do not have a Behaviour support plan.
  + Policies and procedures are available to staff in hardcopy, which staff said they refer to when seeking guidance on processes. The hardcopy restrictive practice policy has not been updated since 2019 and does not capture legislative changes. Management provided an updated copy, confirming the policy had been updated by an external contractor and was available online.
  + The Plan for continuous improvement shows restrictive practice usage was reviewed in June 2022. There was no information to indicate if environment restraints were considered or a review of staff practice in relation to administration of chemical restraints was completed.

The provider’s response did not dispute the Assessment Team’s findings. The response included actions taken in response to the Assessment Team’s report, supporting documentation and a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* + Training has been provided or planned in relation to antimicrobial stewardship, restrictive practices, Behaviour support planning and open disclosure.
  + Registered staff have been reminded to alert General practitioners about pathology services.
  + Implemented a new reporting system which covers infection analysis, trends and actions undertaken with preventative measures.
  + Completed Behaviours support plans for two named consumers.

I acknowledge the provider’s response. However, I find at the time of the Review Audit, the organisation did not demonstrate an effective clinical governance framework or systems relating to antimicrobial stewardship and minimisation of restrictive practice.

In relation to antimicrobial stewardship, pathology testing prior to commencement of antimicrobials is not routinely undertaken, which is not in line with the organisation’s policy and Clinical indicator reports and meeting minutes do not identify antimicrobial interventions used to treat infections. I find such processes do not ensure effective prevention, management or control of infections and antimicrobial resistance or that antimicrobials are prescribed in line with best practice guidelines.

In relation to minimising use of restrictive practices, while management asserts an updated restrictive policy, inclusive of the types of restrictive practice and requirement of Behaviour support plans, was available electronically, staff said they refer to a hardcopy policy which has not been updated since 2019 and is not reflective of legislative requirements. All consumers subject to restrictive practices, including environmental and mechanical, had not been identified nor were Behaviour support plans in place as required under the *Quality of Care Principles 2014*. While the Physiotherapist had identified consumers were being subject to restrictive practice in August 2022, actions taken to address these practices were not undertaken by the service with staff indicating these practices are ongoing. As such, I find the organisation’s systems and practices do not ensure restrictive practices are identified or managed in accordance with legislative requirements or opportunities to minimise use of restrictive practices identified or actioned.

I have also considered that the organisation’s clinical governance framework is limited to information relating to antimicrobial stewardship and minimisation of antipsychotic medication, and audits, used to monitor implementation and effectiveness of clinical governance systems, have not been consistently undertaken in line with the audit schedule since April 2022. As such, I find this has not ensured that organisational systems required to maintain and improve reliability, safety and quality of clinical care have been effectively implemented and monitored or opportunities to improve outcomes for consumers identified and actioned.

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

1. The preparation of the performance report is in accordance with section 76Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)