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: | Assessment Contact - Site |
| Activity date: | 19 June 2023 to 21 June 2023 |
| Performance report date: | 17 August 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 A. Kasyan, 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 Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received on 17 July 2023; and
* the performance report dated 3 February 2023 for the Review Audit undertaken on 6 to 8 December 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **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) and (3)(e)**

* Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences and risks to consumers’ health and well-being are identified and management strategies developed to enable staff to provide quality care and services.
* Ensure assessment and planning processes are based on ongoing partnership with the consumer and others the consumer wishes involved.
* Ensure consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services are actively involved in discussions, decisions and planning related to the consumer’s care.
* Ensure effective and timely reviews of care plans, particularly when circumstances change.

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

* Ensure consumers are provided clinical care which is best practice and meets their needs and preferences, specifically in relation to diabetes management and post falls monitoring.
* Ensure consumers’ high impact or high prevalence risks are effectively managed, including risks associated with pain and changed behaviours.
* Ensure accurate records of end of life care provided to the consumers are maintained to evidence provision of palliative care based on consumers’ needs, goals and preferences.
* Ensure consumers’ changes in health or condition are recognised and responded to in a timely manner.
* Ensure appropriate pathology investigations are undertaken where symptoms are presented to better understand the infectious agent and plan to minimise the spread of infection.

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

* Ensure open disclosure process is used when things go wrong.

**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 effectiveness of the provided training is monitored to ensure the knowledge and skills gained by staff from the training is consistently and appropriately applied in practice.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken.

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

* Effective governance systems associated with information management, workforce governance and continuous improvement.
* Effective risk management systems and practices associated with managing consumers’ high impact or high prevalence risks associated with their care, including using incident data to identify trends and deficiencies.
* Ensure the clinical governance framework is effectively implemented and is addressing management of pain, deterioration, diabetes and palliative care. Ensure the framework is reviewed for effectiveness.

# 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. | 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 service was found non-compliant with Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) following the Review Audit undertaken from 6 to 8 December 2022.

At this Assessment Contact, the Assessment Team have recommended all requirements in this Standard as not met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement 2(3)(a)**

Requirement 2(3)(a) was found non-compliant following the Review Audit where it was found assessment and planning was not effective, specifically in relation to diabetes management plans and assessments, behaviours support care plans and not comprehensively assessing risks to the consumer health and well-being. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Behaviour support plans (BSPs) were developed, reviewed, and implemented and staff have been provided training and mentoring in relation to behaviour support strategies, with ongoing reviews of new consumers.

Staff were provided training on diabetes management and associated assessments to inform safe and effective diabetes management.

The service implemented a register to capture all consumers’ high impact, high prevalence risks.

At the Assessment contact the Assessment Team recommended Requirement 2(3)(a) as Not Met and found, whilst improvements outlined in the service’s plan for continuous improvement (PCI) for this requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

In relation to relation to diabetes management:

A diabetes management plan for one consumer was not completed until after 2 months after the entry into the service.

In relation to pain assessment:

Pain assessment and pain monitoring charts were not commenced following reports from a consumer of increased pain levels. The consumer’s representative expressed dissatisfaction with pain assessment and planning providing feedback indicating the existing pain management is not effective.

In relation to behaviour assessment:

Two consumers did not have a BSP completed and for one consumer a BSP was not completed in a timely manner resulting in an incident impacting health and well-being of another consumer that was reported under the Serious Incident Response Scheme.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

In relation to diabetes:

The above-mentioned consumer’s care in relation to diabetes was planned since the consumer’s entry to the service and changes were made. Diabetes management plans and progress notes evidence appropriate planning occurred for the consumer.

In relation to pain assessment:

The consultant had a conversation with the consumer which confirmed the consumer is not satisfied with their pain management and find current pain management not effective. The consumer was offered and agreed to be referred to internal and external health professionals for assessment and advice on person centred pain management interventions.

In relation to behaviour assessment and planning:

One consumer had a behaviour management plan in place at the time of assessment contact. The second consumer did not need one as they did not have changed behaviours requiring support.

Agrees with the finding in relation to the third consumer whose care plan has been reviewed and updated.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 2(3)(a).

I have considered assessment and planning was not effective for 2 of the sampled consumers to inform safe and effective pain management and changed behaviours because the service did not demonstrate effective assessment and individualised care planning occurred which resulted in unmanaged pain and an incident reported under SIRS (Serious Incident Response Scheme).

I have considered the Assessment Team’s report showing that despite the presence of ongoing pain associated with one of the consumer’s diagnoses, documentation showed the consumer’s pain was not assessed for a period of over 2 months. I consider failure to assess the consumer’s pain impacted monitoring of the effectiveness of the pain management interventions.

I have considered absence of behaviour assessment and a care plan did not ensure provision of safe and effective care of the consumer with changed behaviours because staff were not provided information on triggers and person-centred interventions.

For the reasons detailed above, I find Requirement 2(3)(a) non-compliant.

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

Requirement 2(3)(b) was found non-compliant following the Review Audit where it was found assessment and planning did not identify and address consumers’ current needs, goals and preferences, including advance care planning and end of life planning. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Nurses were re-educated to commence end-of-life (EOL) pathways for palliative consumers when the palliative care plan was activated.

The palliative care procedure and process was updated, and training packages were released to all clinical staff in April 2023.

Lifestyle staff were trained in goals for individual consumers following the admission process.

At the Assessment contact the Assessment Team recommended Requirement 2(3)(b) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found the service could not demonstrate assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning. The Assessment Team’s report provided the following evidence relevant to my finding:

Seventeen of 35 files did not include consumers’ goals, specifically in relation to communication, verbal, sensory, mobility, injury/risk, pain, toileting and oral health.

One consumer’s care plan did not include the consumer’s current needs and contained old information.

An EOL pathway was commenced and then ceased for 2 consumers without evidence of collaborative discussions involving the consumer and their family.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

Goals of care have now been completed for all consumers.

The care plan for the consumer whose needs reflected in the document were not current, has since been updated.

EOL checklists were commenced by a person no longer employed at the service and as such the reasoning behind commencing the checklist without consultation with family is not known. However, the service is taking steps to further increase education regarding palliative and EOL care with training to be provided through Department of Health and Ageing.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 2(3)(b).

I acknowledge the provider’s response showing updated goals of care for consumers. However, a review of the document titled General Goals of Care shows almost identical goals of care for all consumers formulated as nursing goals of care, such as ‘skin will remain intact’. I find this shows the provider’s lack of understanding of the intent of this requirement which is to have a discussion with the consumer about what the consumer hopes to achieve in terms of their health, well-being and quality of life. The provider in its response did not demonstrate consultation with consumers occurred to determine their goals.

I have also considered EOL checklists on 2 instances were completed without involvement of a consumer or consumer representative which is essential for identifying and addressing the consumer’s unique needs, goals and preferences towards the end of their life.

For the reasons detailed above, I find Requirement 2(3)(b) non-compliant.

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

Requirement 2(3)(c) was found non-compliant following the Review Audit undertaken where it was found the service did not engage with consumer representatives on an ongoing basis in relation to review of care needs or assessments. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Staff were reminded to consult with consumers and representatives during care plan evaluations or when a consumer’s assessed needs changed.

Thirteen of 35 care plans have been reviewed and discussed with the consumer or representatives between 15 December 2022 to 14 April 2023.

At the Assessment contact the Assessment Team recommended Requirement 2(3)(c) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

Most representatives and consumers stated they have not seen or been informed about assessments and care plans.

End-of-life checklists for two consumers were commenced without evidence of consultation with their representatives. For both consumers end of life checklists were ceased soon after they were commenced when consultation with families occurred.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

End of life checklists were commenced by a person no longer employed at the service and as such the reasoning behind this action is not known.

Acknowledges there is an opportunity for improvement in this requirement, specifically in relation to keeping the substitute decision maker informed, where there is a change in the consumer’s health status, or an emergency situation.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 2(3)(c).

I find the provider does not demonstrate ongoing partnership with the consumer and others that the consumer wishes to be involved in assessment, planning and review of the consumer’s care and services.

I have considered the Assessment Team’s finding that most representatives and consumers stated they have not seen or been informed about assessments and care plans. The provider’s response does not include any specific evidence and information showing the consumer and their representatives are actively involved in discussions, decisions and planning related to the consumer’s care. This requirement emphasises the importance of collaborative care planning processes, including input from the consumer, representatives and other parties which the provider failed to demonstrate.

Whilst there is some evidence in the documents attached to the provider’s response of collaboration with others, such as medical officers, registered nurses and physiotherapists, professionals, it does not provide sufficient information about how care and services are coordinated with other health care providers, organisations and individuals involved in the consumer’s care.

Lastly, I have considered end of life checklists for two consumers were commenced without consultation with the consumer or their representative. I consider the failure to involve consumers or their representatives in discussions regarding end-of-life care shows lack of effective systems and processes in place to enable shared decision-making and partnership in care planning.

For the reasons detailed above, I find Requirement 2(3)(c) non-compliant.

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

Requirement 2(3)(d) was found non-compliant following the Review Audit where it was found 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.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Thirteen of 35 care plans have been reviewed and discussed with the consumer or representatives between 15 December 2022 and 14 April 2023.

Care evaluation guidelines were issued to all Registered Nurses (RNs) to ensure consultation with consumers/representatives occurs.

At the Assessment contact the Assessment Team recommended Requirement 2(3)(d) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

Three of 6 representatives stated they are not contacted in relation to assessments and care plans, nor have they viewed care plans.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

Feedback from consumers is sought on an ongoing basis regarding satisfaction with their care and services.

As details have not been provided regarding consumers and representatives, the provider cannot provide specific response in relation to the three representatives’ feedback about not receiving information about outcomes of assessment and care planning.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 2(3)(d) is Compliant.

I considered information in the Assessment Team’s report accross Standard 2 that shows each consumer at the time of the Assessment Contact had a care plan and staff confirmed they have ready access to it via an electronic care management system or via hard copy summary care plans.

Whilst three of 6 representatives stated they are not contacted in relation to assessments and care plans, nor have they viewed them, I consider this evidence alone cannot be relied upon to establish whether the service failed to communicate outcomes of the assessment and planning to the consumer. Whilst the care and services plan should be readily available to each consumer, when it comes to representatives, it should only be available to those representatives that are authorised to have a copy of it and the report does not specify this information.

I have also considered that some consumer representatives said they have been given a copy of a care plan and whilst they reported not all information in the care plan was accurate, the intent of this requirement is about providing each consumer and/or other authorised person an access to the care plan and a copy of it if the consumer wishes.

This requirement also highlights the importance of sharing the results of assessment and planning with the consumer. This includes informing the consumer about their health status, identified needs, risks and the proposed plan of care. The Assessment Team’s report and documentation in the provider’s response provides examples of communicating outcomes of assessment and planning face to face, through case conference and phone calls.

For the reasons detailed above, I find Requirement 2(3)(d) is compliant.

**Requirement 2(3)(e)**

Requirement 2(3)(e) was found non-compliant following the Review Audit where it was found care plans have not been regularly reviewed in line with the service’s process of four monthly regular review.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Care plan evaluations are monitored on an ongoing basis by designated key personnel. However, the Clinical Consultants stated this has not been implemented.

At the Assessment contact the Assessment Team recommended Requirement 2(3)(e) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. Consumers’ care needs were not updated when their health deteriorates, or they returned for hospital. The Assessment Team’s report provided the following evidence relevant to my finding:

Three of 6 representatives stated they have not been involved in the reassessment process.

Five consumers’ care plans were not reviewed for effectiveness following incidents and change in condition, such as on return from hospital:

One consumer’s care plan was not reviewed for effectiveness following a return from hospital where the consumer was transferred due to the consumer’s concerns of unmanaged pain. The consumer’s pain care plan was not reviewed following increased pain and medication changes.

The second consumer’s care plan was not reviewed following an increase in falls and falls management strategies were not reviewed for effectiveness after each fall. The consumer sustained 5 falls within a month.

The third and the fourth care plans were not reviewed when there was a deterioration of the consumers’ wounds.

The fifth consumer’s care plan was not updated to reflect a change in the consumer’s condition when the consumer stopped displaying changed behaviours.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

In relation to the first consumer:

Pain review has now been completed and ongoing education and monitoring of staff practices regarding pain charting and pain management to be conducted.

In relation to the second consumer:

The Assessment Team’s report contains inaccurate information. The consumer sustained 4 falls not 5. Falls preventative strategies were reviewed following each fall, investigation into the causative factors was conducted. A urine sample was collected following 2 consecutive falls, antibiotics were commenced for an identified urinary tract infection, a pain chart was commenced, and the consumer was reviewed by a physiotherapist in a timely manner.

In relation to the third and fourth consumers:

Wound care plans were reviewed for effectiveness following a change in the consumers’ condition and updated resulted in healing of the wound and/or timely treatment of infection.

The service updated the fifth care plan to accurately reflect current consumer’s needs and condition.

Based on the Assessment Team’s report and the provider’s response, I find the service is non-compliant with Requirement 2(3)(e).

I find the service does not demonstrate effective and timely reviews of care plans, particularly when circumstances change, to ensure that consumers’ needs are met and that the care provided remains effective and aligned with their preferences.

I considered two of five sampled consumers’ files were not reviewed for effectiveness following a change of circumstances. I have considered one consumer’s care plan was not reviewed on return from hospital and following increased pain and medication changes. The second consumer’s care plan was not updated to reflect a change in the consumer’s condition when the consumer stopped displaying changed behaviours. I am satisfied three other consumers’ files sampled by the Assessment Team were reviewed for effectiveness as demonstrated by the evidence in the provider’s response.

For the reasons detailed above, I find Requirement 2(3)(e) 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. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(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 service was found non-compliant with Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(e) and 3(3)(g) following the Review Audit undertaken from 6 to 8 December 2022.

At this Assessment Contact, the Assessment Team have recommended all requirements in this Standard as not met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement 3(3)(a)**

Requirement 3(3)(a) was found non-compliant following the Review Audit where it was found Medical Officer directives were not consistently followed to ensure effective management of blood glucose levels, medications were not consistently administered in line with best practice processes and the use of a restrictive practice was not in line with best practice care or with legislative requirements.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

All clinical staff completed training and medication administration competencies in December 2022.

Clinical Consultants completed monitoring of medication administration practices in March 2023, providing education and feedback to clinical staff.

At the Assessment contact the Assessment Team recommended Requirement 3(3)(a) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found clinical care is not best practice in relation to falls, wound management and diabetes. The Assessment Team’s report provided the following evidence relevant to my finding:

An internal audit undertaken by the Clinical Consultant in May 2023 identified policies and procedures in relation to clinical and personal care are in place, however, these are not followed by staff.

In relation to wound management:

Consumer A has stage 2 pressure injury to one of their heels. The wound management plan was not updated to accurately reflect changes in the wound dressing product. Wound photographs do not indicate the wound is healing as it shows signs of infection.

Consumer B has an unstageable pressure injury to one of their heels. On one occasion, a wound care product applied during wound treatment, was different to the one listed on the wound care plan. There was a delay of 4 days with updating a wound management plan when a wound care product was changed.

For both Consumer A and B, wound photographs did not consistently include a measuring tape and were not taken from a consistent angle to clearly visualise the wound.

In relation to falls management:

Care documentation for 3 consumers show observations following falls are not taken as per the service’s procedure in relation to frequency of neurological observations.

One of the sampled consumers sustained a head injury and was reviewed by a medical officer soon after the fall. Documentation showed staff did not follow the medical officer directions and ceased monitoring of the consumer’s neurological status 7 hours earlier.

A representative of Consumer C said the consumer’s falls are occurring due to the consumer standing up and no staff available to assist with mobility. Documentation showed the consumer sustained 5 unwitnessed falls over one month’ period and falls risks assessments have not been reassessed in line with the organisation’s policies and procedures.

In relation to diabetes management:

Documentation showed diabetic monitoring directives were not completed for 2 of 3 consumers and as required insulin was not being administered in line with medical directives.

For two of the sampled consumers, ‘as required’ insulin was not administered as per the medical officer’s directives with the number of times the medication was not administered as directed being 7 and 31 respectively.

Additionally, staff were checking blood glucose readings 30 minutes to one hour outside of the time documented in the medical officer’s directive.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

In relation to wound management:

Wound charts of Consumer A reflect the correct wound product was used. The wound was reviewed by a Medical Officer when signs of infection were noted, and antibiotics were commenced resulting in resolution of infection. Medical officer’s progress notes show satisfaction with existing wound treatment.

Consumer B’s wound has resolved.

Education to staff will be provided in relation to taking high quality photographs.

In relation to falls management:

Staff will be monitored to ensure post fall management protocols are implemented correctly.

The service will contact the agency staff provider to notify them of the agency staff who failed to follow the medical officer’s directives.

Consumer C had 4 falls not 5 and 3 falls that occurred over 4 days were related to the urinary tract infection contributing to impulsiveness of the consumer and attempts to walk without waiting for staff assistance. The infection was treated and resolved. The consumer has not sustained any further falls.

In relation to diabetes management:

Timing of blood glucose monitoring was not always on exactly at the same time because it was given before meals to enable administration of insulin with food as per best practice.

Blood glucose directives and hypoglycaemia/hyperglycaemia form was updated and will be given to medical officer for an update and medication management system will be updated to reflect information from the directives.

Handover sheets have been updated to alert all staff, including agency of the requirement to assess the need for administration of ‘as required’ insulin.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 3(3)(a) is non-compliant.

I consider the service does not provide safe and effective best practice clinical care to consumers that is tailored to the consumers’ individual needs and optimises their well-being, specifically in relation to diabetes management and post fall management. In relation to wound management, I reviewed the provider’s response and wound charts attached which shows wound care was provided in line with the consumer’s care plans. In addition, wounds are reviewed every week by a registered nurse and photographs are taken weekly or when there is a significant change which shows ongoing monitoring of the effectiveness of the wound treatment plan.

I find medication management, specifically in relation to management of diabetes, is not best practice and does not support safe delivery of care. Diabetes management directives tailored to each consumer’s individual needs, goals and preferences are not available to staff, and multiple consumers did not receive time critical medication to manage diabetes on up to 31 instances indicating a systemic failure in medication management practices within the service which the service’s monitoring processes did not identify.

I have considered the Assessment Team’s report finding that staff were aware and had access to information on best practice post fall management, however, they have not monitored consumers post fall for a length of time recommended by either a medical officer or written in the procedures. Staff did not effectively monitor at least three consumers indicating a systematic failure in post fall management care, including where a consumer sustained a head injury as a result of the fall which required more close monitoring.

For the reasons detailed above, I find Requirement 3(3)(a) non-compliant.

**Requirement 3(3)(b)**

Requirement 3(3)(b) was found non-compliant following the Review Audit where it was found the service did not demonstrate consumer’s individual risks associated with their behaviours, wound care and/or pain were managed effectively.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Training for all staff relating to repositioning, management of wounds, pain and behaviours and incident management.

Implementation of a new wound care process which requires clinical staff to print an unresolved wound report daily for effective monitoring of wound care.

Implementation of bed tags to guide staff on the appropriate resting height for consumers, with the Physiotherapist undertaking regular audits.

The commencement of high-risk meetings.

At the Assessment contact the Assessment Team recommended Requirement 3(3)(b) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found high impact or high prevalence risks associated with pain management, behaviour support, pressure injuries and restrictive practices are not managed effectively. The Assessment Team’s report provided the following evidence relevant to my finding:

In relation to pain management:

* Whilst care planning documentation shows Consumer D has ongoing pain requiring both regular and ‘as required’ analgesia, there was no documented evidence of pain charting or administration of ‘as required’ analgesia for over a 2 month period.
* Consumer E was commenced on a 5-day pain chart. However, staff did not correctly assess pain as they used inappropriate assessment tools. The representative said they feel the consumer no longer has pain and it is not an issue.
* Consumer F’s representative believes the consumer has unmanaged pain due to showing physical aggression towards staff during activities of daily living. Twenty-three entries were made during a 10-day period with staff using different pain assessment tools. Evaluation of the pain charting showed pain management strategies were effective despite signs of pain, such as physical aggression during activities of daily living.

In relation to behaviour management and restrictive practices, two consumers’ files showed the following:

* Where Consumer F showed changed behaviours, such as calling out, yelling, and screaming or becoming physically and verbally aggressive during activities of daily living, documentation showed pain management interventions were not trialled.
* Consumer G had ongoing wandering at night and agitation. However, a behaviour support plan was not developed to identify triggers for these behaviours and manage all risks to this consumer and to others. As a result, the consumer’s unmanaged behaviours resulted in an impact to another consumer, a SIRS incident.
* In relation to Consumer H, there were 2 occasions where ‘as required’ medication was administered for anxiety. However, there were no evidence alternative strategies were trialled prior to administration of medication that was identified as chemical restraint.

In relation to pressure injuries risks:

* Repositioning charts of one consumer with existing pressure injuries showed inconsistent completion.
* The second file showed the consumer was not on repositioning chart despite existing pressure injury.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

In relation to pain management:

Agrees staff do not use right pain assessment tools. Education will be provided to staff and staff adherence to using right tools will be monitored.

The consultant had a conversation with Consumer D which confirmed the consumer is not satisfied with their pain management and find current pain management not effective. The consumer was offered and agreed to be referred to internal and external health professionals for assessment and advice on person centred pain management interventions.

The representative of Consumer F made the decision to cease analgesia which was assisting in managing the consumer’s pain. This has been discussed with the representative following the assessment contact visit who agreed to re-commence analgesia to reduce pain levels and to improve staff ability to provide care to the consumer.

In relation to behaviour support and restrictive practices:

Agrees behaviour charting did not correctly identify trends in changed behaviours and additional education was provided to the clinical nurse regarding the review of charting and looking at effectiveness of strategies.

Processes for checking ‘as required’ psychotropic medication is administered appropriately have been reviewed and education to a clinical staff member overseeing it has been provided.

In relation to management of pressure injuries risks:

Monitoring of staff compliance with completing repositioning charts will be enhanced.

One of the two consumers’ pressure injury has resolved, and the second consumer’s pressure injury was treated with antibiotics, was reviewed by a medical officer who was satisfied with the treatment plan.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 3(3)(b) is non-compliant.

I find the service does not effectively manage high impact or high prevalence risks associated with pain, changed behaviours and restrictive practices. In coming to my finding, I have placed weight on evidence in relation to Consumers D, E, F, G and H.

I find the service did not effectively managed risks associated with pain for Consumers D and F. Staff did not use appropriate pain assessment tools and did not identify signs of pain, resulting in unrecognised and unmanaged pain for Consumers D and F for a prolonged period.

Changed behaviours of Consumers F, G and H were not managed effectively. Consumers’ changed behaviours were not followed by review of interventions and their effectiveness and triggers to the consumers’ changed behaviours were not identified and addressed resulting in unmanaged pain, an incident which impacted another consumer and inappropriate use of chemical restraint.

I find pressure injuries risks for two consumers were managed effectively. I have considered one of the two consumers’ pressure injury has resolved, and the second consumer’s pressure injury was treated with antibiotics, was reviewed by a medical officer who was satisfied with the treatment plan. I find repositioning charts alone cannot solely be relied upon to establish effectiveness of pressure injuries prevention and management plans.

For the reasons detailed above, I find Requirement 3(3)(b) non-compliant.

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

Requirement 3(3)(c) was found non-compliant following the Review Audit where it was found the service did not demonstrate needs, goals and preferences of consumers nearing the EOL are recognised and addressed to ensure their comfort was maximised and dignity preserved. It was found end of life pathways were not commenced, appropriate assessments were not undertaken, and progress notes did not demonstrate the care provided to consumers at the end stage of their lives to ensure their comfort was maximised.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Training and resources were given to all staff and discussed at the staff meeting in February 2023.

Consumers commenced on end-of-life care are entered onto the high-risk register to ensure EOL care is commenced and managed effectively.

At the Assessment contact the Assessment Team recommended Requirement 3(3)(c) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. Two consumer records showed information about end-of-life care provided to the consumers towards the end of their lives was either not documented or documented incompletely and inaccurately. The Assessment Team’s report provided the following evidence relevant to my finding:

In relation to the first consumer:

* There was no evidence in care documentation the representative had been consulted on the end-of-life needs, goals, and preferences of the consumer.
* A medical officer prescribed medications for end-of-life care based on the consumer’s change in condition. However, there has been no documentation regarding end-of-life care for a month before the consumer’s passing.

In relation to the second consumer:

* The consumer did not have a palliative care plan.
* Whilst end of life pathway was commenced, it was not completed consistently with no evidence of monitoring of the symptoms for 4 hours on 2 days.

Additionally, an internal audit undertaken by the Clinical Consultant in May 2023 identified end of life care is being commenced for consumers who are not on end of life. In response to these findings, an action plan was commenced which included providing training to clinical staff.

The Approved Provider did not dispute the Assessment Team’s findings and responded by stating systems are currently in place but require stringent monitoring and follow up as they are not yet imbedded into day-to-day staff practices. The Approved Provider has commenced an action plan to address the gaps identified by the Assessment Team.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 3(3)(c) is non-compliant.

I considered the Assessment Team’s findings based on review of documentation of two consumers which showed the service does not maintain accurate records of end-of-life care provided to the consumers to evidence provision of palliative care based on the consumers’ needs, goals and preferences.

Additionally, I have considered the provider’s response which does not dispute the Assessment Team's findings and acknowledges the need for further improvement in education regarding palliative and end-of-life care. I consider the provider’s agreement with the finding shows they recognise deficiencies in their staff current practices related to the provision of end-of-life care.

For the reasons detailed above, I find Requirement 3(3)(c) non-compliant.

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

The Assessment Team recommended Requirement 3(3)(d) as Not Met because they found the service does not recognise nor respond to deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition. Two consumer records showed staff did not escalate consumers’ change in condition with hospital transfers being initiated in response to consumer and/or consumer representatives’ request. The Assessment Team’s report provided the following evidence relevant to my finding:

In relation to the first consumer:

* The service did not respond to the consumer’s gradual deterioration over a 5 month period evidenced by gradual weight loss, decreased appetite, symptoms of nausea and increased pain.
* Additionally, the service did not recognise or responded appropriately to the consumer’s acute deterioration resulting in a hospital transfer at the request of the consumer. On the day, when the consumer was transferred to hospital vital signs observations were recorded only once, 30 minutes before ambulance arrival and showed abnormal reading. There have been no other records of the consumer’s monitoring in observation charting or progress notes despite nausea and small vomits 4 days prior to the hospital transfer. The consumer returned to the service with the diagnoses, including delirium secondary to sepsis.

In relation to the second consumer:

* In the 24 hours leading up to the transfer to hospital, progress notes show the consumer had increased pain requiring ‘as required’ pain relief to be administered. In response to severe pain clinical staff administered analgesia and reassured the consumer that medication will work to relieve pain. However, the consumer’s representative contacted the hospital to arrange a hospital transfer as per the consumer’s wishes.
* The consumer returned from hospital with new medication regimen for pain management.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

In relation to the first consumer:

The consumer’s condition and medical history is quite complex presenting many challenges, specifically in relation to management of weight loss, loss of appetite and abnormal bowel pattern associated with the consumer’s diagnoses. The general practitioner was informed of the consumer’s symptoms and weight loss and appointments to an external service provider were made which the consumer chose not to attend. The consumer was referred to and reviewed by a dietitian twice over specified period.

Staff monitored and acted on increased pain and nausea and appropriately identified and responded to the consumer’s acute deterioration.

In relation to the second consumer:

The consumer’s representative contacted an ambulance while a nurse was taking vital signs.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 3(3)(d) is non-compliant. The service did not demonstrate for 2 sampled consumers sudden deterioration of a consumer’s physical condition was recognised and responded to in a timely manner.

In relation to the first consumer, I consider the service recognised the consumer’s gradual deterioration over at least a 4 months period and escalated it appropriately through a range of actions, such as sending referrals to the specialists which the consumer chose not to attend.

However, I consider the consumer’s acute deterioration over a three-day period was not recognised and responded to in a timely manner. Whilst the service recognised and responded to gastrointestinal changes, such as nausea and vomiting by administering medication, no evidence was provided in the provider’s response showing if the service closely monitored the consumer’s vital signs, physical appearance and mental status.

The provider’s response, however does not provide evidence of the consumer’s observations that were “within an acceptable range” and which were taken on one occasion on the day when new symptoms developed and the second time, three days after, on the day when the consumer was hospitalised. Whilst the provider does not clarify what actions and steps are to be taken by staff at the service to support them to recognise and respond to consumers’ deterioration, I consider 2 sets of vital signs observations taken three days apart does not demonstrate adequate response to the consumer’s change in condition.

Lastly, I have considered hospital transfer was arranged at the consumer’s request and the hospital discharge summary showed the consumer was diagnosed with delirium secondary to sepsis – this indicates a significant failure to identify a change in the consumer’s condition.

In relation to the second consumer, I consider the service did not demonstrate they actioned the change in the consumer’s pain level adequately. In the 24 hours leading to hospital transfer the consumer’s vital signs were not monitored and were only taken after the representative informed the service they are calling ambulance themselves. Whilst pain relief was administered in response to increased pain, no other assessments and actions were taken by staff to assess the situation and provide appropriate care.

Monitoring and tracking changes in vital signs and other observations over time plays a significant role in detecting acute deterioration, which the provider did not demonstrate in the care of the two consumers.

For the reasons detailed above, I find Requirement 3(3)(d) non-compliant.

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

Requirement 3(3)(e) was found non-compliant following the Review Audit where it was found the service did not demonstrate care plans used by staff to provide care were up to date and reflective of consumers’ current care needs and preferences.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* The care plan review process was updated and implemented in March 2023.
* Care plan reviews are to be monitored and undertaken by the delegated clinical staff member.

At the Assessment contact the Assessment Team recommended Requirement 3(3)(e) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found information about the consumer’s condition, needs and preferences is not documented and not communicated within the organisation and with others where communication is shared. The Assessment Team’s report provided the following evidence relevant to my finding:

* An internal audit undertaken by the Clinical Consultant in May 2023 identified the handover folder was not being used to facilitate effective communication to staff, and care plans were not up to date.
* At the time of the Assessment Contact, printed care plans were all identified to have been printed on 19 June 2023, the day of the Assessment Contact.
* Staff stated they do not read the care plans on the floor as they know the consumers and know what care needs they require.
* Pain and behaviour charting for 2 sampled consumers were not completed accurately.
* Two medication incidents were not communicated to a representative of two sampled consumers.

The Approved Provider responded by stating systems are currently in place but require stringent monitoring and follow up as they are not yet imbedded into day-to-day staff practices. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* Consumer summary care plans required updating and therefore were re-printed on 19 June 2023.
* Further education and increased in monitoring of staff will be conducted to ensure accuracy of pain and behaviour charting completion and evaluation.
* In relation to one of the two medication incidents, it was not reported to the consumer’s representative because the investigation showed it related to the process of documenting medications that are being returned to the pharmacy, and the consumer received their medications as prescribed.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of Not Met and find the service is compliant with Requirement 3(3)(e).

In coming to my finding, I have considered each consumer at the time of the assessment contact had a care plan and staff confirmed they have access to it via an electronic care management system or via hard copy summary care plans. In relation to staff statements that they do not read the care plans on the floor as they know the consumers and know what care needs they require, I consider this information alone cannot be relied upon for establishing if staff only rely on their familiarity with consumers and do not receive relevant information about consumer’s condition, needs and preferences via other systems, including regular communication and updates on consumer care plans.

All consumers and representatives said they were generally happy with the personal and clinical care being provided suggesting staff are aware of the consumers’ condition, needs and preferences and provide care accordingly.

The service has an electronic care management system to store and share consumer information, ensuring important details are accessible to those involved in the consumer’s care.

The Assessment Team reports in Requirement 8(3)(b) states clinical incidents are reported, discussed at various meetings.

I accept one of the consumer’s incidents was not communicated to a consumer’s representative however I consider it is not suggestive of system wide deficiencies around how the service uses incident management system to communicate information about the consumer’s condition within the organisation including with consumer representatives.

For the reasons detailed above, I find Requirement 3(3)(e) is compliant.

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

Requirement 3(3)(g) was found non-compliant following the Review Audit where it was found the service did not demonstrate implementation of precautions to prevent and control infections, including strategies to manage COVID-19 infections. Additionally, the service did not demonstrate it promotes appropriate antibiotic use to reduce the risk of antimicrobial resistance.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* All staff completed mandatory infection control training.
* Infection-related risks and processes have been reviewed. An updated policy was implemented in May 2023.
* The service implemented an outbreak management kit that is readily available to staff.

At the Assessment contact the Assessment Team recommended Requirement 3(3)(g) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found the service does not minimise infection related risks through implementation of standard and transmission-based precautions or practices to promote appropriate antimicrobial prescribing. The Assessment Team’s report provided the following evidence relevant to my finding:

In relation to standard and transmission-based precautions:

* The service does not have an Infection Prevention Control (IPC) lead.
* A staff member was observed not performing hand hygiene prior to or following the administration of medication to a consumer.

In relation to practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics:

* Two consumers were prescribed antibiotics for suspected urinary tract infection for displaying signs of infection, such as increased confusion and agitation. Whilst in one of two cases a urine sample was collected and sent to pathology for analysis, there was no evidence of follow up and review of the results of microbiological cultures to ensure that the most effective antibiotic was used for the identified pathogen.
* One consumer with a wound infection was prescribed antibiotics without a wound swab sample being obtained.
* Two clinical staff advised they were not familiar with the term antimicrobial stewardship. However, they described some principles of it, such as tailoring antimicrobial therapy based on the specific pathogen causing the infection. Additionally, staff advised the process for obtaining wound swabs is not implemented due to difficulties to collaborate with health professionals prescribing antimicrobials.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

Staff attempt to collect urine sample. However, it is not always possible, such as in case of one of the consumers mentioned in the Assessment Team’s report.

Acknowledges, antibiotics were prescribed prior to/ or without a sample being sent to pathology to determine the specific pathogen. Further education to be completed with staff and consultation with general practitioners to determine process for initiating requests for pathology testing to ensure Antimicrobial Stewardship principles are followed.

Since the Assessment Contact, a designated person has finished relevant course and became an Infection Prevention Control Lead.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 3(3)(g) is non-compliant. I find whilst the service ensures minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection, the service has not implemented effective processes to ensure appropriate and effective use of antimicrobial agents to optimise consumer outcomes while minimising antimicrobial resistance and adverse effects.

In relation to standard and transmission-based precautions, I consider a single observation of a staff member not washing their hands prior to and after a medication administration for one consumer cannot be relied upon to establish staff practices in relation to hand hygiene.

I have also considered the Assessment Team’s report findings showing the service minimise infection related risks through staff training on infection control, implementing policies and procedures and collation of infection incident data and trend analysis. I considered the infection incident data showed a downward trend since January 2023 suggesting that the implemented infection control measures are effective in reducing the incidence of infections.

However, I consider the service did not implement appropriate actions following the Review Audit to ensure minimisation of infection related risks through implementing practices to promote appropriate antibiotic prescribing.

I consider the service’s processes being ineffective to support the identification of the relevant pathogen and the service have not created the relationship with the prescriber to support practices of antimicrobial stewardship.

For the reasons detailed above, I find Requirement 3(3)(g) non-compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service was found non-compliant with Requirements 5(3)(b) and 5(3)(c) following the Review Audit undertaken from 6 to 8 December 2022.

At this Assessment Contact, the Assessment Team have recommended Requirement 5(3)(c) is met and Requirement 5(3)(b) is not met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

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

Requirement 5(3)(b) was found non-compliant following the Review Audit where it was found 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. Additionally, the external courtyard area was not well maintained, and placement of gym equipment. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Where consumers cannot move freely outdoors due to the risks to their health and well-being, environmental restraint consent have been obtained from the relevant consumers and/or their representatives.

Staff members were advised by memorandum of the regular practice for the locking and unlocking of the door accessing the internal courtyard.

Maintenance removed weeds, and external, internal courtyard cleaning and maintenance has been added to preventative maintenance schedules.

Dumbbells removed from windowsills and the 2 palm trees located in the internal courtyard were cut back and made safe which was observed during the Assessment Contact.

Walls and skirting boards throughout the service are being repaired and painted. During the Assessment Contact, half of the corridors had been painted and the skirting boards had been repaired.

At the Assessment contact the Assessment Team recommended Requirement 5(3)(b) as Not Met and found, whilst improvements have been completed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

Thirty-three consumers cannot freely move outdoors due to the main front doors and sensory garden door being protected by keycode access with only 2 consumers being given the access code.

The 2 entry gates in the carpark are also connected to security and fire systems, however, one front gate has not been functioning for over 6 months.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

The practice of the door to the sensory garden being unlocked every morning was compromised as the lock was found to not be working to allow this to occur. A replacement lock is being fitted which can be unlocked and locked with a key which will not compromise the service’s fire safety.

A new process has been introduced where a registered nurse is to unlock the door each morning and lock each evening. As a backup measure both Maintenance and Lifestyle staff now have a key and check the door when they arrive for duty.

Door code cards are in place and have been positioned at the front door and in each room (apart from those consumers under authorised Environmental Restraint) so that all consumers and their visitors have clear egress through each door. Example have been provided to the Assessment Team.

The gates are currently left open at all times.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 5(3)(b) is Compliant.

I am satisfied the provider rectified deficiencies identified in the Assessment Team’s report to enable consumers to move freely indoors and outdoors.

I also find the service environment is safe, clean, well maintained and comfortable. Fire provisions are checked by external providers, and portable electrical equipment is regularly inspected. Preventative building maintenance schedules are in place, and staff were knowledgeable of the process for reporting maintenance issues and broken equipment. Emergency evacuation maps and procedures were observed to be displayed throughout the service and at the main fire panel. Fire safety provisions are inspected and monitored by an external contractor.

Based on the Assessment Team’s report I find Requirement 5(3)(b) is compliant.

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

Requirement 5(3)(c) was found non-compliant following the Review Audit where it was found some equipment used in the provision of consumers’ care and services was not well maintained. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Oxygen cylinders have been tested, maintained, and secured by chains.

Process put in place for oxygen cylinders and oxygen/suction units checks.

Two comfort chairs were purchased and 2 were reupholstered.

At the Assessment contact the Assessment Team recommended Requirement 5(3)(c) as Met and found, improvements have been completed and equipment was observed to be safe, clean, and well-maintained.

The service uses paper-based documentation system for monitoring preventative and reactive maintenance for furniture, fittings, and equipment. Cleaning staff provided records for the cleaning and upkeep of laundry equipment. Consumers stated equipment in their rooms was cleaned regularly by staff, and other equipment and fittings within the service were observed to be well maintained. However, gym equipment in the internal courtyard was observed to be dusty with cobwebs and have been cleaned in response to the Assessment Team’s feedback. Management advised cleaning of the gym equipment will be included to the cleaning schedule.

Based on the Assessment Team’s report I find Requirement 5(3)(c) is compliant.

# Standard 6

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| Feedback and complaints | |  |
| 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. | Compliant |

Findings

The service was found non-compliant with Requirements 6(3)(c) and 6(3)(d) following the Review Audit undertaken from 6 to 8 December 2022.

At this Assessment Contact, the Assessment Team have recommended Requirements 6(3)(c) and 6(3)(d) are not met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

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

Requirement 6(3)(c) was found non-compliant following the Review Audit where it was found the service did not consistently undertake follow up of complaints and did not maintain a feedback log to enable effective monitoring of complaints data.

At the Assessment contact the Assessment Team recommended Requirement 6(3)(c) as Not Met and found, whilst improvements around open disclosure practices have been completed and staff received relevant training in relation to open disclosure, the service could not demonstrate appropriate action has been taken in response to feedback and complaints. The Assessment Team’s report provided the following evidence relevant to my finding:

Staff could not provide examples of how they practice open disclosure.

Two medication incidents have not been reported to consumer and/or consumer representative and open disclosure did not take place.

A SIRS incident was not reported in line with the legislative requirements and an open disclosure occurred with a three month delay.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

The newly appointed management is aware of the process of open disclosure and further education regarding open disclosure will be conducted.

In relation to the SIRS incident, the open disclosure log was completed in the electronic care management system.

In relation to one of the two medication incidents, it was not reported to the consumer’s representative because the investigation showed it related to the process of documenting medications that are being returned to the pharmacy, and the consumer received their medications as prescribed.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 6(3)(c) is non-compliant.

I find the service does not show open disclosure process is consistently used when things go wrong which is evidenced through lack of communication, delayed reporting and inefficient staff training. I have considered open disclosure process was not used or was not used in a timely manner in relation to two incidents and this did not allow consumers and families to be informed about potential risks and changes in their care.

I accept open disclosure in relation to SIRS incident was practised, however, this did not occur until after 3 months after the incident occurred. I consider delayed reporting does not demonstrate effective practicing of open disclosure because it indicates a failure to promptly communicate adverse events to consumers and their families and this may adversely impact transparency and the building of trust.

Finally, I considered staff are not effectively trained in open disclosure because despite training provided in December 2022, they could not provide examples of open disclosure process.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 6(3)(c) is non-compliant.

**Requirement 6(3)(d)**

Requirement 6(3)(d) was found non-compliant following the Review Audit where it was found complaints were not reviewed and used to improve the quality of care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

The feedback register was updated in December 2022.

The consumer experience report was planned to be implemented in April 2023. However, this has not been implemented yet.

At the Assessment contact the Assessment Team recommended Requirement 6(3)(d) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

There have been 17 feedback and complaints captured in the feedback log since January 2023, however, feedback has not been captured from Residents’ and Representative meeting.

Staff were able to describe how they handle verbal feedback, however, when it is resolved on the spot, a form is not filled out and is not captured in the feedback log.

Management was able to describe what continuous improvement initiatives have been identified through consumer feedback and provided one example of improving the central courtyard area in winter and putting in decking, however, this was not captured in the plan for continuous improvement or feedback log.

In response to a SIRS incident, management agreed to install CCTV cameras throughout the service to monitor consumers’ safety. While captured in the feedback log, the service has not actioned this improvement or captured it in the plan for continuous improvement.

Management said continuous improvement initiatives and the plan for continuous improvement are discussed at Quality Improvement Committee meetings. No Quality Improvement Committee meetings have been held this year, the first one is scheduled for June 2023.

Consumer Experience Surveys undertaken monthly capture a score out of 4, with 0 being not satisfied to 4 being satisfied. Although the results from the survey completed in June 2023 showed a high number of consumers were satisfied, review of the survey’s showed some low scores in satisfaction. Documentation and progress notes did not demonstrate additional feedback was sought as to why the consumers were not satisfied.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. The provider submitted the following information and evidence relevant to my finding in this Requirement:

Feedback form meetings will be added to the register.

Ongoing education is being provided to staff conducting any audit of the requirement to follow up and implement actions following identification of concerns or as in this case a low outcome of scoring.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of Not Met and find the service is Compliant with Requirement 6(3)(d).

I find the service reviews feedback and complaints data and uses it to improve the quality of care and services.

The evidence presented in the Assessment Team’s report shows the service engages consumers and their families through regular meetings which shows the service’s commitment to involving them in decision-making. Whilst not captured on the service’s plan for continuous improvement the service demonstrated actions taken in response to feedback and suggestions voiced by consumers at these meetings, such as improvements to the outdoor area and installation of security cameras. Additionally, I considered the provider’s commitment to capture all consumer feedback on the feedback register for effective monitoring.

Consumer surveys are conducted regularly and show high level of consumers are satisfied with the quality of care and services. Furthermore, the Assessment Team’s report in Requirement 8(3)(a) states consumers said they are engaged in improving the delivery of care and services and Resident and Representative meetings minutes for March, April, May 2023 show focus group discussion on projects around the building and consumers were encouraged to provide feedback on what can be improved at the service resulting in actions, including around improvements to the lifestyle program and environment. Results from the February 2023 satisfaction survey showed high rate of consumer satisfaction (90%) were discussed as well as improvements resulted from surveys, such as adding more activities to the lifestyle program.

The provider’s response demonstrated a follow up with the consumer identified in the Assessment Team’s report who provided a low score to one question in response to consumer experience survey. The provider also expressed its commitment to improve capturing of improvements and actions on the PCI and/or Feedback log.

For the reasons detailed above, I find Requirement 6(3)(d) compliant.

# Standard 7

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| Human resources | |  |
| 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 service was found non-compliant with Requirements 7(3)(c), 7(3)(d) and 7(3)(e) following the Review Audit undertaken from 6 to 8 December 2022.

At this Assessment Contact, the Assessment Team have recommended all requirements in this Standard as not met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement 7(3)(c)**

Requirement 7(3)(c) was found non-compliant following the Review Audit where it was found the workforce did not have sufficient knowledge and skills to effectively perform their roles, specifically in relation to management of changed behaviours, restrictive practices, incident reporting, wounds, pain, medications and infection control. Additionally, the service’s processes have not been effective in monitoring the workforce are working within their scope of practice.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

An information sheet on restrictive practices was given to all new staff, with a package developed in relation to restrictive practices and behaviour support plans through the orientation process.

Staff received training in relation to management of pain, diabetes, wound treatments, antimicrobial stewardship and changed behaviours.

At the Assessment contact the Assessment Team recommended Requirement 7(3)(c) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

Staff interviews confirmed staff did not have the knowledge in relation to open disclosure and when it is practiced.

Documentation showed staff did not competently identify, report, record or monitor three consumers’ deterioration following a change in their condition. This includes failure to maintain contemporaneous accurate records and monitoring the consumer’s condition through ongoing monitoring and assessing their vital, neurological signs and pain levels.

Documentation showed staff did not competently assess consumers’ pain using inappropriate pain assessment tools and did not completely identify consumers’ personal goals.

Staff were not competent or knowledgeable in relation to identifying and reporting a SIRS incident line with the organisation’s procedures or in line with legislative requirements. The deficit in staff practice has not been identified over a significant period of time.

Clinical staff did not appropriately or effectively manage and monitor consumers following incidents of falls including where head injuries occurred and did not administer medications as prescribed for diabetes management.

The service did not have effective processes to identify deficits in clinical staff knowledge or competency in performing their roles.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. The provider submitted the following information and evidence relevant to my finding in this Requirement:

Review of onboarding and mandatory education program to be completed, all clinical staff to complete the educational process to prove competency in all aspects of the role. While this process is undertaken additional monitoring of consumers will be conducted by the relevant key personnel with support from the Clinical and Quality Consultants.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 7(3)(c) is non-compliant.

I find the service does not demonstrate staff are competent or have required the knowledge to effectively perform their roles.

I have considered findings in Standard 3 where staff were identified as not competently performing clinical assessment and management of consumers’ pain, deterioration and incidents including falls. They were identified as not identifying, reporting or responding to serious incidents in line with the knowledge required to meet the Quality Standards. Staff reported they do not know what open disclosure is and when it is to be used.

The service has multiple processes in place to monitor staff competence in performing their roles including onboarding, orientation, training, supervision and feedback and complaints mechanisms. However, the service failed to identify deficits in staff competence and knowledge in performing their roles in delivering safe and effective care to consumers.

I have also considered the deficits in staff competence were identified across multiple staff and over a prolonged period of time, since the Review Audit in December 2022, indicating a systemic deficit in the service’s systems in relation to ensuring staff are competent and knowledgeable in performing their roles.

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

Requirement 7(3)(d)

Requirement 7(3)(d) was found non-compliant following the Review Audit where it was found the workforce did not have sufficient knowledge and skills to effectively perform their roles, specifically in relation to management of changed behaviours, restrictive practices, incident reporting, wounds, pain, medications and infection control. Additionally, the service’s processes have not been effective in monitoring the workforce are working within their scope of practice.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Mandatory training records were up-to-date and contained a list of current staff and training records.

Mandatory training records showed 72.5% of staff had completed mandatory modules. This included completion by 6 of 11 Clinical staff and 23 of 29 care staff.

Where mandatory training has not been completed, staff were either new or unavailable, and a second training day has been organised in July 2023 with a memo sent out to staff.

At the Assessment contact the Assessment Team recommended Requirement 7(3)(d) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

While additional training is provided to staff in addition to mandatory training, not all staff completed the additional training, including in relation to antimicrobial stewardship, pain check, diabetes and psychotropic medication. Whilst the above training was provided, it was not effective as evidenced in in Standard 3 in relation to the service not demonstrating delivery of safe and effective clinical care.

Some staff advised they have not had training in relation to restrictive practices.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

Training in relation to restrictive practices was conducted in June 2023 for all care staff and all but 5 nursing staff members with follow up education packages issued to all nursing staff.

Review of onboarding and mandatory education program will be completed.

All clinical staff will be required to complete the educational process to prove competency in all aspects of the role.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 7(3)(d) is non-compliant.

I find whilst the workforce is trained, it is not supported to deliver the outcomes required by these standards.

I have considered the service has a structured and ongoing training program which includes mandatory training and additional training specific to the roles of staff and the program covers various aspects of care delivery and these Quality Standards.

I acknowledge, at the time of the Assessment contact not all staff completed mandatory training, this was due to staff either new or unavailable. I consider the service has since provided additional training sessions to relevant staff and there are more training sessions scheduled to be delivered.

I acknowledge the provider’s response demonstrating since the Assessment Contact, a designated person has finished relevant course and became an Infection Prevention Control Lead.

However, I find while training is an important component of this requirement, the intent of this requirement is to ensure the trained workforce delivers care that aligns with these Quality Standards. I have considered poor care outcomes, especially around pain, diabetes, falls, deterioration management and infection prevention, demonstrated in multiple requirements across Standard 3 Personal care and clinical care indicates the training is not effectively leading to better care practices. I consider the knowledge and skills gained from the training is not consistently or appropriately applied in practice.

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

**Requirement 7(3)(e)**

Requirement 7(3)(e) was found non-compliant following the Review Audit where it was found the service did not have effective systems in place to ensure regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Some staff performance appraisals have been completed since December 2022.

Related policy and procedures were reviewed in January 2023.

Training schedule was reviewed, with gaps in staff skills and knowledge identified and training added to the training program for 2023.

At the Assessment contact the Assessment Team recommended Requirement 7(3)(e) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team’s report provided the following evidence relevant to my finding:

Staff could not describe the last time they had a performance appraisal.

There is a Performance Management Procedure requiring development of a clear plan of action with the employee to implement a solution either through a Performance Improvement Plan (PIP) or Action Plan with trainings or development, and management to monitor performance as appropriate and reasonable through meetings.

However, the service did not demonstrate the above process was being followed for three staff members who have been performance managed. There was no documentation related to formal monitoring for 2 of three staff members, training provided and/or scheduled, or completed PIPs.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. For example:

Should an investigation into performance be initiated, legal advice should be sought to ensure the process taken is one of procedural fairness to staff members. Complex staff performance issues are raised with Senior Management.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 7(3)(e) is non-compliant and the service does not demonstrate it undertakes regular assessment, monitoring and review of the performance of each member of the workforce.

I have considered whilst there are policies on performance management, these are not followed, and there is no documented evidence of formal monitoring for the staff members who are under performance management. I find the service does not regularly assess and monitor the performance of its staff. In addition, not all staff members have completed performance appraisals since this process was re-commenced in December 2022.

Furthermore, I have considered findings in Standard 3 Requirement 3(3)(a) of multiple consumers not receiving time critical medication to manage diabetes over a prolonged period of time and this was followed up on with responsible staff members until after medication incidents were identified by the Assessment Team, indicating a systemic failure the service’s monitoring processes of performance of each staff member.

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

# Standard 8

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

Findings

The service was found non-compliant with Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) following the Review Audit undertaken from 6 to 8 December 2022.

At this Assessment Contact, the Assessment Team have recommended Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) as not met and Requirement 8(3)(a) as met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

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

Requirement 8(3)(a) was found non-compliant following the Review Audit where it was found consumers were not actively engaged in the development, delivery and evaluation of care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Consumer surveys implemented and Consumer Experience surveys were conducted in February and March 2023.

Newsletters distributed to consumers, representatives, and staff.

The service implemented a feedback register and open disclosure log.

Complaints are now reported to the Board monthly by the service manager.

At the Assessment Contact, the Assessment Team found the service demonstrated improvements have been effective and consumers are engaged in the development, delivery and evaluation of care and services. Consumers confirmed they are involved in the development of care and services and participate in surveys which are discussed at the Residents’ and Representatives meetings. They felt the service is run well and are engaged in improving the delivery of care and services.

Resident and Representative meetings minutes for March, April, May 2023 show focus group discussion on projects around the building and consumers were encouraged to provide feedback on what can be improved at the service. Results from the February 2023 satisfaction survey showing high rate of consumer satisfaction, 90% were discussed as well as improvements resulted from surveys, such as adding more activities to the lifestyle program.

Board members are present at the service at least 3 times a week and engage with consumers during their visits.

For the reasons detailed above, I find Requirement 8(3)(a) is compliant.

**Requirement 8(3)(b)**

Requirement 8(3)(b) was found non-compliant following the Review Audit where it was found the service did not demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for service delivery, specifically in relation to ineffective reporting processes from service management to the governing body to ensure the governing body is aware of and accountable for the delivery of care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Monthly reports are provided from the Site Manager to the Board of Directors (BOD) which include key clinical and operation information.

Board meetings occurring as per the meeting plan.

A review of overarching organisational policies and procedures has been completed by the Clinical Consultants.

The Staff Code of Conduct was circulated to all staff to read and sign they understand content. Education was also provided at staff meetings.

Staff Code of Conduct information was provided to consumers at Residents’ and Representatives meetings and information circulated in newsletters.

The organisation’s Strategic Plan review of governance is ongoing.

At the Assessment Contact, the Assessment Team found improvements have not been effective and the service was unable to demonstrate the organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. The Assessment Team’s report provided the following evidence relevant to my finding:

The service manager provides the Board of Directors with monthly statistical data collection containing high injuries and high prevalence clinical indicators, incident data, education and staff development, regulatory compliance, and occupancy reports. However, these reports have not been effective to enable the governing body to ensure continuous improvement to meet the Quality Standards.

The organisation’s Governance and Quality and Risk Management Framework sets and prioritises the strategic direction of the organisation and ensures identification, monitoring and reporting of high risk or high prevalence clinical matters. However, the governing body was unable to demonstrate that systems to ensure staff understand and enact their responsibilities throughout the service via appropriate structures, policies, processes to delivery safe clinical care were effective.

The service manager provides the Board of Directors with monthly statistical data collection containing high injuries and high prevalence clinical indicators, incident data, education and staff development, regulatory compliance, and occupancy reports. However, these reports have not been effective to enable the governing body to ensure continuous improvement to meet the Quality Standards.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. The provider advised the Board of Directors sought additional training and support through the Aged Care Industry Association in relation to the new governance requirements. Education was provided by in March 2023.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is compliant with Requirement 8(3)(b).

I find the organisation adequately demonstrates its compliance in line with the intent of this requirement and demonstrates it ensures the leadership and governance of the organisation actively contribute to creating an environment where the well-being, safety and right of consumers are prioritised. I have considered the following evidence and information in the Assessment Team’s report that support my finding:

The organisation’s Governance and Quality and Risk Management Framework sets and prioritises the strategic direction of the organisation and ensures identification, monitoring and reporting of high risk or high prevalence clinical matters.

The organisation is overseen by three Board of Directors with 2 Board of Directors having clinical backgrounds. The Board meets quarterly or more often if required. The service employs a service manager and a Clinical Nurse who both have leadership responsibilities at the service.

The Board of Directors advised, in addition to the monthly statistical data collection received from the Site Manager, they also visit the service 2 or 3 times per week and meet with staff, consumers and the service manager. The service manager provides the Board of Directors with monthly statistical data collection containing high injuries and high prevalence clinical indicators, incident data, education and staff development, regulatory compliance, and occupancy reports.

Clinical incidents are reported, discussed at General Staff, daily catch-up and buzz meetings and escalated to the governing body monthly.

I have also considered evidence in Requirement 8(3)(a) showing the governing body encourages involvement of consumers and their families in decisions related to care planning and service delivery.

I find that the deficits presented by the Assessment Team in this requirement are in relation to continuous improvement, workforce governance and risk management system are more aligned with the intent of Requirements 8(3)(c) and 8(3)(d) where this information was considered.

For the reasons detailed above, I find Requirement 8(3)(b) is compliant.

**Requirement 8(3)(c)**

Requirement 8(3)(c) was found non-compliant following the Review Audit where it was found the service did not have effective governance wide systems specifically in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Call bell system upgraded, and reports completed for January 2023.

Feedback register and open disclosure log in place, monitored by the Board.

Complaints reported to Board monthly or as required.

Review of organisational policies and procedures.

Review of Incident management system, training provided to management.

Management communicated the new Code of Conduct legislation to staff, consumers and representatives through meetings, newsletters, training, and memoranda.

Consumer surveys implemented and Consumer Experience surveys conducted in March 2023.

Quality Improvement and Work Health and Safety recommenced in March 2023.

Reviewed meeting schedules and agendas.

New process for staff appraisals commenced in January 2023, includes orientation package for students.

Reviewed mandatory training requirements, completed an excel spreadsheet for staff attendance to be recorded accurately.

Training plan developed to prioritise training which included evaluation tools, questionaries, and competency of staff knowledge.

Registered Nurses are rostered each shift with additional support of Enrolled Nurses during the day and there are two Clinical Managers monitoring with a service manager assisting on the floor.

At the Assessment contact the Assessment Team recommended Requirement 8(3)(c) as Not Met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. At the Assessment Contact, whilst there are effective organisation wide systems around financial governance, systems and processes relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints are not effective. The Assessment Team’s report provided the following evidence relevant to my finding:

Information management

Staff do not have Digital Enhanced Cordless Telecommunications (DECT) phones to enable them to respond or effectively communicate with other staff, especially in the event of an emergency, such as falls, behaviours or other medical emergencies.

Management were unable to generate call bell reports to monitor call bell response times.

Although clinical indicator data is collected monthly and forwarded to the Board and reported at bi-monthly Staff meetings, data in relation to feedback and clinical incidents is not being effectively reported to enable trending, analysis and reporting to occur.

Continuous improvement

The PCI in place only identified actions in response to the deficits identified from the Review Audit in December 2022. The PCI does not include improvement initiatives, such as feedback from Residents’ and Representatives meetings, surveys, incidents, or internal audits so improvements can be planned and actioned promptly.

Staff said, and care documentation reviewed showed consumers’ incidents are not consistently reported which does not enable effective trending and analysis of incidents to identify continuous improvement initiatives.

Workforce governance, including the assignment of clear responsibilities and accountabilities

The service has overarching Corporate Governance policies and procedures which describes Board members’ and management responsibilities, accountabilities, and accounting authorities. Duty statements for all staff, appraisal and performance management processes are in place. However, deficiencies in relation to workforce competencies, training, and supporting and mentoring staff performance have been identified.

The service did not provide evidence to demonstrate the workforce is provided with an appropriate induction and supervision to deliver safe and quality care and services. The organisation does not provide adequate monitoring to gauge staff competency and ensure performance is being regularly reviewed.

Management oversight of staff performance and monitoring is inconsistent and performance appraisals are overdue.

Regulatory compliance

The service receives updates in relation to changes in legislation and requirements. Policies and procedures have also been updated to reflect these changes. However, these were not effective in alerting the organisation to support compliance with relevant Requirements as management and staff were not aware of requirements relating to minimising restrictive practices, such as chemical and environmental restraint.

Feedback and complaints

Whilst some areas of feedback and complaints were effective, deficiencies were identified relating to processes for recording, monitoring, evaluation and trending feedback and complaints.

It was not evident from Board Minutes and monthly reports provided by the service manager to the Board that feedback and complaints from consumers were being regularly and consistently used to inform further improvement activities.

Monthly reports from the service manager had limited if no actions and/or effectiveness of previous actions listed, and the reports only indicated how many complaints had been received.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

In relation to staff not having access to DECT phones, in emergency situation staff will use ‘multi press’ of the attendance button. This in turn will send an emergency message and alert sound across the service with the annunciators providing the location the call point.

Pager functionality is being installed as a part of the continuous call bell system improvement.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 8(3)(c) is non-compliant.

I find there are effective organisation wide governance system in relation to financial governance, information systems and processes, feedback and complaints and regulatory compliance. However, I find systems in relation to Continuous improvement and Workforce governance are not effective.

Staff said they can access the information they need, including consumers’ care plans, progress notes and staff communications via the electronic care system. The service’s policies and procedures are readily available to staff. There are systems and processes to receive updates in relation to changes in legislation and requirements and relevant policies and procedure are up-to-date. The organisation also retains and has access to legislation relevant to aged care and other regulatory bodies legislation. There is a structured process for receiving, addressing and resolving complaints and concerns. Feedback is used to make decisions for improvements.

Continuous improvement

I find the organisation could not demonstrate it focuses on continuous improvement. At the time of the Assessment Contact the service’s plan for continuous improvement showed all improvements related to the findings from the Review Audit undertaken in December 2022 have been completed and closed. I acknowledge the provider’s response confirming there are still improvements to be made and deficits that remained have been transferred to the Self-Assessment which was completed in May 2023.

However, a review of extracts from self-assessment and planned actions shows the provider did not identify people responsible for ensuring implementation of each planned action, did not include a completion date for each planned action, and did not include a review date to evaluate the success and sustainability of each planned action. I consider by not including these key elements into the continuous improvement plan shows the provider has not implemented effective mechanisms to monitor the progress of improvement initiatives on an ongoing basis to ensure review, monitoring and evaluation of actions.

Workforce governance, including the assignment of clear responsibilities and accountabilities

I have considered workforce governance systems are not effective, specifically in relation to ineffective staff training and development, and inadequate performance feedback. I have relied upon evidence in Standard 7 showing systems and processes do not identify deficits in staff competence and knowledge in performing their roles in delivering safe and effective care to consumers; whilst training is provided, the knowledge and skills gained from the training is not consistently or appropriately applied in practice and policies on performance management are not followed.

For the reasons detailed above, I find Requirement 8(3)(c) is non-compliant.

**Requirement 8(3)(d)**

Requirement 8(3)(d) was found non-compliant following the Review Audit where it was found the service did not have 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 evidence of actions taken to address deficiencies identified, including, but not limited to:

An environmental audit was completed in December 2022.

Management completed online training through the ACQSC on Effective Incident Management Systems and Monitor and assess the performance of your service in January 2023.

Incident reporting policies and procedures were reviewed to ensure they are contemporary and in line with best practice.

Education undertaken for all staff on documentation and incident management, including SIRS on the 6 April 2023. A complementary educational package was developed and released to all clinical staff on the 11 April 2023.

An Incident Management System audit was completed on the 19 May 2023 and action plan developed. One-to-one education was provided to management regarding the follow up and closure of incidents.

Commencement of high-risk meetings was completed on the 3 May 2023; however, meetings were not held following this date due to a change of management. Meetings are planned to recommence every 2 weeks following the Assessment Contact.

A policy and procedure review by the Clinical Consultants has been completed.

At the Assessment contact the Assessment Team recommended Requirement 8(3)(d) as not met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found the service has effective risk management systems and practices to support consumers to live the best life they can. However, they found ineffective risk management systems and processes in relation to managing and escalating high impact or high prevalence risks, responding to the potential neglect of consumers, and ensuring appropriate protections and safeguards are in place to mitigate identified risk. The Assessment Team’s report provided the following evidence relevant to my finding:

The service did not provide any clinical audits. The service did complete a Personal Care and Clinical Care audit which forms part of their audit schedule and addresses policies and procedures, care plan reviews, infection control practices, risk assessments and diabetic management plans. The audit does not cover wound, nutrition, hydration, skin integrity, medications, infections, or pressure area care.

As outline in Standard 3 consumers’ risks in relation to pain, falls and deterioration were not effectively managed.

Consumers’ changed behaviours are not effectively managed as incidents are not completed and root causes of changed behaviours are not analysed.

The incident management folder showed 6 SIRS incidents from January to June 2023, one out of three was submitted to the Commission outside of legislative timeframe. One incident was not submitted until after it was discussed with the Assessment Team and was lodged as a priority 2 SIRS.

One Priority 1 SIRS incident was submitted with the delay of over 3 months.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. 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 submitted the following information and evidence relevant to my finding in this Requirement:

A new process has only recently commenced with the new service manager where progress notes are reviewed daily as an additional way to identify high impact high prevalence risks, including in relation to pain, changed behaviours and falls.

Clinical auditing schedule will be reviewed and updated to ensure auditing is conducted effectively and used to identify deficits and act on finding to improve outcomes for consumers and staff.

Full care plan reviews of three consumers identified in the Assessment Team’s report for infective management of pain, changed behaviours and falls have been conducted in consultation with the consumer of their representative and changes made accordingly.

Acknowledge staff did not complete behaviour charting and did not complete incident reports.

Acknowledge a Priority 1 SIRS incident was submitted with the delay of over 3 months. However, the clinical Consultants and Director acted promptly once they became aware of the incident. Interview conducted with care staff member on the day of identification. Interview conducted with a clinical staff member who failed to report the incident. Police was notified the day of identification. Open disclosure process was followed and a full care plan review conducted by the following identification of the incident.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 8(3)(d) is non-compliant. I find the service does not have effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers and identifying and responding to abuse and neglect of consumers.

I have considered the service failed to identify and report two incidents falling under category of Serious Incident Response Scheme. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement or risks to consumers’ health and well-being are minimised and/or eliminated.

I have 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 pain and changed behaviours as highlighted in Standard 3 Personal care and clinical care Requirements (3)(a) and (3)(b). The deficits were in relation to care of multiple consumers over prolonged period of time which have not been identified by the organisation’s risk management system.

For the reasons detailed above, I find Requirement 8(3)(d) is non-compliant.

**Requirement 8(3)(e)**

Requirement 8(3)(e) was found non-compliant following the Review Audit where it was found the did not demonstrate an effective clinical governance framework or systems relating to antimicrobial stewardship and minimisation of restrictive practice. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

Monthly reports are now provided to the Board which include key clinical and operation information.

Clinical staff completed mandatory training on antimicrobial stewardship in December 2022 and January 2023.

Clinical staff completed mandatory restrictive practices training in December 2022.

Managers completed on-line training session on Monitoring and assessing the performance of an Aged Care Service in January 2023.

A staff training package has been developed in relation to dementia, problem solving for behaviours, including Behaviour support plans and restrictive practises. This is to be used for onboarding new staff.

Policies and procedures have been updated to reflect legislative changes around restrictive practices completed by the Clinical Consultants.

A review of restraints was completed, consents obtained and appropriate BSPs completed.

The commencement of high-risk meetings was completed on the 3 May 2023; however, meetings were not held following this date due to a change of management occurring. Meetings are planned to recommence every 2 weeks following the Assessment Contact.

At the Assessment contact the Assessment Team recommended Requirement 8(3)(e) as not met and found, whilst improvements outlined in the service’s PCI for this Requirement states the improvements have been completed and closed, the service could not demonstrate they have been fully imbedded. The Assessment Team found the serviced does not have an effective clinical governance framework for the use of antimicrobial stewardship, minimising restraint, and organisation wide systems for supporting and communicating open disclosure. The Assessment Team’s report provided the following evidence relevant to my finding:

In relation to antimicrobial stewardship:

Progress notes viewed shows antibiotics are being administered prior to swabs sent to pathology and not in line with the service’s policy.

Clinical staff could not describe principles in relation to antimicrobial stewardship.

Management advised a medical officer does not allow specimens to be sent prior to the prescribing of antimicrobials.

In relation to minimising the use of restraint:

The service’s front door is secured by keypad lock. The service did not ensure consumers have code to the keypad lock to enable free movement.

There was an incident where a chemical restraint was administered to a consumer at the request of a family member without a medical officer’s order and staff member was lowering a consumer’s bed restricting their movement without ensuring it was necessary and used as a last resort.

Open disclosure:

Staff demonstrated a lack of knowledge and awareness regarding open disclosure.

Two medication incidents have been disclosed to a consumer or their representative and open disclosure did not occur.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included abstracts from their Self-Assessment in relation to the service’s improvement activities. The provider’s response included actions taken in response to some of the deficits identified. The provider submitted the following information and evidence relevant to my finding in this Requirement:

In relation to antimicrobial stewardship:

Further education to be completed with staff and consultation with medical officers to determine processes for initiating requests for pathology testing to ensure Antimicrobial Stewardship practices are followed.

In relation to minimising the use of restraint:

The door code cards were implemented during the assessment contact and shown to the auditors. Since the visit cards with the door code have been attached to the wall in each room above the light switch for all consumers who do not have authorised environmental restraint in place.

A registered nursing staff involved in the incidents of inappropriate use of mechanical and chemical restraint was terminated following the organisation’s process

In relation to open disclosure:

The electronic reporting system has an Open disclosure form which the home has commenced using. This form will allow the home to run reports on all Open Disclosure conversations conducted. Further education will be provided to ensure all staff are aware of the system.

One medication incident was not an incident but rather documentation error relating to the pharmacy processes.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 8(3)(e) is non-compliant.

In coming to my finding, I have considered there is a clinical governance framework, including in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure and there is no evidence of systemic deficiencies in these components.

However, I consider the intent of this requirement is not limited to the three components. Whilst the clinical governance framework exists, evidence in Standard 3 shows systemic deficiencies in provision of clinical care, including in relation to pain, palliative care, diabetes management and identification and response to acute deterioration. I find the existing framework is not effectively preventing or addressing these issues and is not improving the quality of clinical care.

I have also considered the provider’s response showing they identified through self-assessment a need for a review of the organisation’s Clinical Governance Framework to ensure it sets out the key structures, systems and processes that enable organisational wide responsibility and accountability for quality care and services. The provider is considering the commencement of a Clinical Governance Committee.

For the reasons detailed above, I find Requirement 8(3)(e) is non-compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)