Performance

Report

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| Name: | Serene Residential Care Services |
| Commission ID: | 6820 |
| Address: | 1 Myzantha Street, LOCKLEYS, South Australia, 5032 |
| Activity type: | Site Audit |
| Activity date: | 4 December 2023 to 6 December 2023 |
| Performance report date: | 19 January 2024 |
| Service included in this assessment: | Provider: 3424 Blu Dawn Pty Ltd  Service: 4264 Serene Residential Care Services |

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

**This performance report**

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

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

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

# Material relied on

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

* The assessment team’s report for the Site Audit conducted from 4 December 2023 to 6 December 2023. The 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 3 January 2024, including a Plan for Continuous Improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified.
* A self-assessment submitted by the provider and received on 18 October 2023 as part of the application for re-accreditation. The self-assessment information demonstrates the provider’s performance or planned performance, in relation to the service, against the Quality Standards.
* The performance report for the assessment contact – site conducted from 19 June 2023 to 21 June 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **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 2(3)(b) and 2(3)(e)

* Ensure consumer care plans identify and address consumer’s current and individualised needs, goals and preferences, specifically in relation to falls prevention, behaviour support and lifestyle choice and needs.
* Ensure assessments and care plans are reviewed for effectiveness when consumer’s circumstances change, including timely and consistent monitoring and evaluation of pain, oral intake, falls risk and changed behaviour.

Standard 3 Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e)

* Ensure each consumer gets safe and effective clinical care, including the effective management of care related high impact or high prevalence risks and consumers’ changed condition. This include:
  + effective fluid intake monitoring when consumers requiring fluid restriction
  + consistent monitoring of blood glucose level and administer additional insulin when required
  + comply with organisational policy and procedures and complete all required monitoring observations following falls incidents, including vital signs observations and neurological observations
  + following health professionals instructions and complete planned weighing for consumers who are losing weight or at risk of losing weight
  + safe medication administration including always checking allergy information
  + correctly identify chemical restraint and ensure effective assessment, authorisation and management
  + use alternative strategies prior to the use of psychotropic medication for consumer's changed behaviour.
* Ensuring information about the consumer’s condition, needs and preferences is documented and communicated within the organisation.

Standard 7 Requirements 7(3)(d) and 7(3)(e)

* Ensuring the workforce is competent, effectively trained and have the knowledge to effectively perform their roles and deliver the outcomes required in relation to the management of pain, fluid restriction, diabetes, deterioration, weight loss, medication, chemical restraint and behaviour support.
* Ensuring all staff competing mandatory onboarding training in a timely manner.
* Ensuring training delivered will be measured to confirm effectiveness in supporting safe and effective care delivery.

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

* Ensuring the organisation’s governing body promotes a culture of safe and quality care, especially in relation to clinical care.
* Ensuring organisation wide governance systems relating to information management and workforce governance are effective.
* Ensuring effective risk management systems and practices in relation to the managing clinical care related high impact or high prevalence risks. Ensuring incidents are identified, reported, analysed to improve care delivery and prevent further similar incidents.
* Ensuring clinical governance framework is effective to promote antimicrobial stewardship and minimise the use of restraint. Ensuring the framework is effective in preventing, identifying, monitoring or addressing systemic clinical deficiencies and improves the quality of care delivery.

# Standard 1

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

Findings

Consumers confirmed they are treated with dignity and respect by staff. Consumers said they feel valued and safe when receiving care and services as their culture is respected and their identity is maintained. Consumers and representatives advised consumers are supported to engage in risky activities of their choosing to enable them to live the best life they can; this includes risk assessment and risk mitigation processes. Consumers said they are supported to exercise choice and independence, make decisions about their care and services and choose who is involved in the decision-making process.

Staff were familiar with consumers’ backgrounds, cultural needs, identity and preferences. Observations of staff interactions with consumers and others including visiting representatives were respectful and kind. Staff showed understanding in consumers’ relationships with families and friends and how this influenced their involvement in care and services.

Sampled care planning documents were reflective of consumers’ backgrounds, cultural, beliefs and traditions. Consumers’ choices around when care and services are delivered, who is involved in care and how the provider supports them in maintaining relationships were detailed. Sampled consumers’ risk assessments outlined consumers’ chosen activity, discussions with the consumer and/or their representative regarding risks associated with the activity and interventions to minimise the risks to support consumers.

Information provided to consumers is communicated clearly and is easily understood. Information is provided through a range of avenues, including emails, noticeboards, meeting forums and one-to-one visits. Consumers were happy with the information provided to them and indicated staff were very good at verbally communicating information. The organisation has policies and procedures in place to ensure consumer privacy is respected and confidentiality of consumers’ information is maintained. Staff were observed to knock on consumers’ doors prior to entry and closing the door during provision of care. Information on the electronic documentation system is secured with usernames and passwords ensuring restricted access.

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

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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. | 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

Following non-compliance with Requirements 2(3)(a), 2(3)(b), 2(3)(c) and 2(3)(e) found through the previous performance assessment contact conducted from 19 to 21 June 2023, the provider undertook multiple improvement actions to address deficits identified. Some of the improvement actions, specifically in relation to Requirements 2(3)(a) and 2(3)(c), were implemented successfully.

However, I find Standard 2 Ongoing assessment and planning with consumers non-compliant based on 2 of 5 of the specific Requirements have been found as non-compliant. These include Requirements 2(3)(b) and 2(2)(e). I have detailed reasons for my finding for each Requirement below.

Requirement 2(3)(a)

The assessment team were not satisfied that new consumers’ assessments and planning are completed or considered risks and brought forward:

* Multiple consumers’ assessments were not completed for the period of July 2023 to November 2023 including a newly admitted consumer.
* The assessment and planning process did not identify or document risks to two named consumers’ health and well-being including medication allergy and risk of pain relating to medical diagnosis.

The provider in their response to the assessment team’s report explained a new clinical management structure had been in place since mid-October 2023 to ensure consumer admission assessments are completed appropriately. The provider submitted care plans and completed admission assessments for 5 consumers who entered the service since mid-October 2023 as supporting evidence.

For the two named consumers:

* The provider submitted clarifying information to demonstrate the medication allergy was documented when identified; the provider, however, acknowledged medication administration deficits.
* The provider submitted copy of assessments that considered risk of pain relating to medical diagnosis and a 3 day pain monitoring record as supporting evidence.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, whilst I acknowledge the deficits included in the assessment team’s report relating to medication management which is further discussed in Standard 3 Requirement 3(3)(b), I was persuaded by the provider’s response with supporting evidence that showed assessments and care planning for new consumers are conducted and completed timely since the new management structure being in place, including considered care and services related risks. I also place weight on staff’s knowledge in relation to admission assessments process and the overall positive consumers and representatives feedback captured in the assessment team’s report regarding assessments and care planning process.

Based on the evidence and reasons detailed above, I find Requirement 2(3)(a) compliant.

Requirement 2(3)(b)

The assessment team were not satisfied that consumer’s individualised goals and preferences are identified and documented and stated in their report:

* A consumer’s advanced care plan was generic in nature and did not identify the consumer’s specific preference.
* A consumer’s behaviour support plan did not identify the consumer’s specific risky behaviour to guide staff practice in managing the behaviours.
* Consumers’ lifestyle assessments did not address consumers’ individualised and current goals as 60% of consumers’ lifestyle assessments had the same or very similar goals.

The provider in their response refuted the assessment team’s finding around the named consumer’s advanced care planning. The provider submitted care plan, associated assessments including advanced care directives and spiritual assessment, progress notes and supplementary therapy attendance records to evidence the consumer’s needs, goals and preferences during end of life stage were identified through frequent consultation with the nominated representatives and addressed.

The provider in their response acknowledged the deficits identified relating to the named consumer’s behaviour support plan and submitted an updated version that was completed following the site audit. The provider indicated, through their Continuous Improvement Plan, that all behaviour support plan will be reviewed to ensure information is individualised, accurate and reflective of the consumer’s needs.

In relation to consumers’ lifestyle goals being not individualised, the provider advised the deficits were already identified prior to the site audit and documented in their Continuous Improvement Plan for further action.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I was persuaded by the provider’s response with supporting evidence that showed the named consumer’s end of life care planning and assessments identified and addressed the consumer’s needs, goals and preference. However, I was not provided evidence to be persuaded that consumers’ behaviour support plan and lifestyle planning are individualised and address consumers’ needs and goals. In addition, I place weight on evidence brought forward by the assessment team under Requirement 2(3)(a) that a consumer’s care planning documents did not reflect all falls management and prevention strategies to address the consumer’s current needs; although the provider had updated the consumer’s falls related assessments and planning document, the service’s own monitoring mechanism did not identify and rectify the deficits prior to it been identified by the assessment team.

The provider is still undertaking improvement actions and I encourage them to embed these improvements into their usual practice to ensure all consumers care plans, including behaviour support plans and lifestyle planning assessment, identifies and addresses the consumer’s current needs, goals and preferences.

Based on the evidence and reasons detailed above, I find Requirement 2(3)(b) non-compliant.

Requirement 2(3)(c)

The assessment team were not satisfied that end of life assessment and planning for two consumers was based on ongoing partnership with the consumer and their nominated representatives. The provider in their response provided limited information for the first named consumer and explained that the consumer passed away prior to the commencement of the current clinical management team. For the second named consumer, the provider refuted the assessment team’s finding and submitted relevant progress notes, care plan and associated assessments to evidence frequent consultation between the provider, medical professionals involved and the consumer’s nominated representatives prior to and during the consumer’s palliating period.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, whilst I acknowledge the lack of documented evidence to demonstrate ongoing partnership for one consumer’s palliative assessment, I was persuaded by the provider’s response with supporting evidence that showed the ongoing partnership in end of life assessment, planning and review process for the second named consumer. I place weight on positive feedback captured in the assessment team’s report that consumers and representatives confirming their involvement in assessment and planning process and stating they are consulted on a regular basis about the care and service delivery. In addition, the assessment team confirmed, through sampled care documentation, the service consults with the consumer’s medical officer, hospital specialists and other allied health services, such as speech pathologists and dieticians, to plan and review care and services.

Based on the evidence and reasons detailed above, I find Requirement 2(3)(c) compliant.

Requirement 2(3)(d)

The assessment team were satisfied that the outcomes of assessment and planning were effectively communicated to the consumer and documented. Consumers and representatives advised they are informed of the outcomes of assessment and planning and have received a copy of the care plan by email or in person, including when a review has been completed. Representatives confirmed they are informed when there are changes to the consumer's needs, or where an incident has occurred. Sampled care plans were developed from information gathered through consultation with consumers and/or representatives and assessment processes. Care plans, assessment and medication charting are captured in an electronic care documentation and medication management system which both clinical and care staff have access to. Staff were observed accessing computers and mobile devices that allow them accessing consumers’ care plans, assessments, monitoring charts, progress notes and for clinical staff, medication charting.

Based on the evidence and reasons detailed above, I find Requirement 2(3)(d) compliant.

Requirement 2(3)(e)

The assessment team were not satisfied that care and services were reviewed for effectiveness when consumers’ circumstances change or following an incident. The assessment team brought forward:

* A named consumer’s behaviour was not monitored or reviewed following the reduction and cessation of psychotropic medication.
* A second named consumer was involved in an incident, whilst behaviour and pain monitoring charting were initiated, they were not consistently documented or evaluated.
* For a third named consumer, pain charting and monitoring was not initiated following the consumer experiencing mobility difficulty relating to chronic pain. The consumer also experienced unplanned weight loss, however, oral intake monitoring chart was not completed consistently and nutritional assessment were not reviewed to ensure effectiveness.
* A fourth named consumer experienced multiple falls however the falls prevention strategies were not reviewed to ensure effectiveness.

The provider in their response provided clarifying information, additional evidence and refuted some of the assessment team’s finding.

* The provider advised the named consumer’s behaviour was monitored and submitted behaviour monitoring record between 1 November 2023 and 17 December 2023 and two behaviour evaluation notes.
* The provider acknowledged deficits identified relating to incomplete monitoring and review for the second named consumer’s behaviour and pain. The provider advised following the new clinical management structure being in place, the consumer’s behaviour and pain assessments had been reviewed and updated.
* The provider submitted complete pain monitoring chart and allied health professional’s review records for the third named consumer. The provider acknowledged deficits relating to incomplete oral intake monitoring chart and included clinical documentation in its Continuous Improvement Plan for further action. An updated dietary assessment, completed after the site audit, was submitted to evidence complete review after the consumer’s condition change.
* For the fourth named consumer, the provider advised relevant falls risk assessments had been updated and the consumer’s care plan now includes an additional falls prevention strategy.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, whilst I am satisfied the provider has a care plan review schedule in place to ensure care plans are reviewed regularly, I am not persuaded that consumers’ care had been reviewed appropriately when circumstances change and impact on the consumers’ needs. Whilst I acknowledge there had been a recent clinical management structure change and the provider is actively taking improvement actions including review and update assessments and care plan following assessment team’s feedback, I place weight on the significant delay in re-assessment and review of consumers’ care after circumstance change or incident. These include behaviour monitoring commenced 11 days after the reduction of psychotropic medication for the named consumer and behaviour and pain assessments review completed more than 40 days later following the incident for the second named consumer. I also place weight on evidence brought forward by the assessment team under Requirement 3(3)(b) regarding a consumer’s pain was not consistently monitored, documented and evaluated. In addition, despite new the clinical management structure in place with increased clinical oversight, the assessment team identified more than 10% consumers’ assessments and care plans with deficits relating to re-assessment and review, I am not persuaded that the provider’s current practice ensures consistent and effective care and services review to meet the consumer’s current needs and goals especially when consumers’ circumstances change.

Based on the evidence and 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. | 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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Following non-compliance with Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d) and 3(3)(g) found through the previous performance assessment contact conducted from 19 to 21 June 2023, the provider undertook multiple improvement actions to address deficits identified. Some of the improvement actions, specifically in relation to Requirement 3(3)(g), were implemented successfully.

However, I find Standard 3 Personal care and clinical care non-compliant based on 4 of 7 of the specific Requirements have been found as non-compliant. These include Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e). I have detailed reasons for my finding for each Requirement below.

Requirement 3(3)(a)

The assessment team were not satisfied that each consumers gets safe and effective care that is tailored to their needs and best practice. The assessment team brough forward:

* Two consumers requiring fluid restriction did not have consistent fluid intake monitoring to ensure safe care provision. When consumers’ daily fluid intake was recorded significantly lower or above prescribed amount, there was no evaluation or following up action to promote effective fluid intake management.
* One consumer requiring blood glucose level monitoring three times a day was only monitored twice a day for 4 of 14 days.
* Staff were not following organisational policy or best practice to complete monitoring observations for two consumer following falls incidents, these include vital signs observations and neurological observations.
* Weekly weighing recommended by allied health professionals were not complete on multiple occasions for 3 consumers.

The provider in their response provided clarifying and additional information and acknowledged deficits relating to ineffective management of fluid restriction, inconsistent blood glucose level monitoring and incomplete or lack of post fall observations. Whilst the provider did not acknowledge the deficits in relation to incomplete weight monitoring, I was not provided with evidence that indicate weekly weighing had been completed consistently for the 3 named consumers. The provider included fluid restriction and diabetes management in the Continuous Improvement Plan for further action.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, despite some consumers’ satisfaction with their care delivery, I was persuaded by the assessment team’s evidence that named consumers did not receive safe and effective clinical care relating to the management of fluid restriction, blood glucose monitoring, falls and weight loss. I acknowledge the provider had reviewed the named consumers’ care following the assessment team’s feedback or after the site audit, the service’s own monitoring mechanism, including internal audits, failed to identify and rectify the deficits prior to it been identified by the assessment team. The provider is still undertaking improvement actions and I encourage them to embed these improvements into their usual practice to ensure safe and effective care and service delivery to all consumers.

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

Requirement 3(3)(b)

The assessment team were not satisfied thathigh-impact or high-prevalence risks associated with the medication and behaviour support were effectively managed. The assessment team brought forward:

* A consumer was prescribed and administered a medication that they were allergic to after the allergy had been identified.
* A consumer did not receive prescribed as required insulin when their blood glucose level was outside of their desired range. The internal audit of diabetic management and insulin administration did not identify the missed insulin administration.
* Alternative strategies were not used prior to the administration of as required psychotropic medication for two consumers. Although a regular high-risk consumer meeting had been established to ensure high-impact and high-prevalence risks are discussed, escalated and followed up, nether consumers’ changed behaviour or psychotropic usage had been mentioned during the high-risk meeting.
* Pain was not monitored, documented and evaluated for two consumers. This information was considered and discussed under Standard 2 Requirement 2(3)(e).

The provider in their response provided clarifying and additional information, including:

* The provider explained signs of allergy reaction had been monitored for the named consumer and there was no adverse outcome resulted. However, the provider agreed there was medication administration deficits for the first and second named consumers and have followed up with staff involved to prevent similar incident.
* The provider did not refute the assessment team’s finding relating not using alternative strategies prior to administer psychotropic medication and advised the missed information within the high-risk register was relating to previous management. The provider had completed a full clinical review of the high-risk register following the site audit and submitted a copy of the register, dated 21 December 2023, to evidence areas of consumer high risks are now captured, updated and maintained appropriately.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I was persuaded by the assessment team’s evidence that named consumers’ risks associated with medication administration and behaviour support have not been minimised or effectively managed. I place weight on the named consumers’ possible or actual adverse outcome relating to the unsafe medication administration and ineffective behaviour support. I also place weight on evidence included in the assessment team report and provider’s response, under Requirement 7(3)(c), that psychotropic medications used in the form of chemical restraint were not effectively identified by staff for 3 consumers. Subsequently these medications were not assessed, consented to and managed. In addition, I was not persuaded that the provider has effective clinical monitoring mechanisms or oversight in place to ensure consumers’ care related risks are properly monitored or managed.

While I note the provider has taken actions in response to the deficits raised in the assessment team’s report, I was not provided sufficient evidence to be satisfied that the service has addressed all of the deficiencies identified, including having the systems and processes to identify and address issues that affect or may affect the effective management of consumers’ high impact or high prevalence risks, review outcomes and adjust staff practice.

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

Requirement 3(3)(c)

The assessment team were satisfied thatthe needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. Care documentation for sampled consumers showed their conditions were monitored through an end of life pathway and appropriate follow up actions were taken when changes in condition had been identified. Clinical and care staff displayed familiarity with the end of life process and knew how to monitor and record the consumer's condition. Staff confirmed they had received training on end of life care and knew where to find information in the policies and procedures when required.

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

Requirement 3(3)(d)

The assessment team were not satisfied that consumers’ deterioration or condition change had been recognised and responded to in a timely manner. The assessment team brought forward:

* For a consumer who experienced recent health decline, whilst their deterioration was recognised and referred to medical professionals for review in a timely manner, follow up actions were not undertaken in line with the medical professionals’ directive to ensure the consumer was monitored for further deconditioning. These include not conducting urinalysis and only attended 40% of required vital signs monitoring within a 7 day period.
* For a second consumer who experienced significant deterioration, although referrals to medical professionals and transfer to hospital occurred in a timely manner, follow up actions were not undertaken to monitor the consumer’s deteriorating condition and prevent associated risks. These include lack of vital sign observations following an episode of chest pain and as required medication administration, incomplete vital signs documentation following acute episode of confusion, lack of pain monitoring after identification of severe pain requiring opioid pain relief, inconsistent oral intake monitoring whilst the consumer was experiencing unplanned weight loss, missing 40% of blood pressure monitoring in a 5 day period despite signs of hypotension and medical professional’s instruction.

The provider in their response acknowledged the deficits identified for the named consumer relating to incomplete urinalysis and vital signs monitoring. The provider advised responsible staff were counselled and reminded of their responsibilities. For the second consumer, the provider in the response provided clarifying and additional information, including progress notes and assessment records, to evidence ongoing review completed by medical and allied health professionals regarding deterioration and associated issues such as mobility decline, pain, weight loss, behaviour change and hypotension.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I was persuaded by the assessment team’s evidence that two named consumers’ deterioration was recognised however not responded to appropriately. I acknowledge the provider’s response demonstrating their engagement with medical professionals when consumer’s deterioration had been identified. However, I was not provided with sufficient evidence, such as records of vital signs and blood pressure monitoring, to be persuaded that the second named consumer’s deterioration was managed effectively. I have considered and discussed the monitoring and evaluation of pain and oral intake in Standard 2 as the evidence is more relevant to the intent of Requirement 2(3)(e).

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

Requirement 3(3)(e)

The assessment team were not satisfied that information about the consumer’s condition, needs and preferences is documented and communicated effectively. The assessment team brought forward:

* One representative stated the consumer’s clinical care needs are not always communicated to other staff.
* Directions and recommendations from health professionals and nursing staff were not communicated effectively and resulted in delays in implementation or incompletion. These include inconsistent monitoring of pain and oral intake and a delay of 7 days when commencing fluid intake observation.
* Ineffective medication allergy documentation resulting a consumer been prescribed and administered a medication to which they are allergic.

The provider included limited information regarding this Requirement in their response. However, the provider had responded to the 3 consumer experience examples in other Requirements.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I was persuaded by assessment team’s evidence demonstrating the service’s processes do not consistently ensure that consumers’ conditions and needs are effectively communicated within the organisation. Whilst I acknowledge that a 7-day handover notes folder was introduced to aid effective communication to nursing and care staff regarding consumers’ conditions and changed needs, I place weight on the representative’s dissatisfaction and evidence captured under other Requirements, including but not limited to:

* Consumers’ assessments and planning documents were not always reviewed and updated to reflect consumers’ current needs, goals and preference.
* Consumers’ behaviour support plan and lifestyle planning were not individualised to guide staff practice and meet consumers’ needs and goals.
* Clinical and care staff were not always aware of consumer’s changed condition and managing strategies.

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

Requirement 3(3)(f)

The assessment team were satisfied with timely and appropriate referrals to other organisations and providers of other care and services. Consumers and representatives said referrals are initiated when consumers need them and confirmed they are satisfied with the referral process and its timeliness. Clinical staff were knowledgeable of the referral process, including when and how to refer consumers to relevant providers of care and services including medical practitioners and allied health professionals. The organisation has policies and procedures in place to guide and support staff in relation to timely and appropriate referrals. The provider’s response for Requirement 3(3)(d) also evidenced their timely engagement with medical and allied health professionals when consumer’s deterioration had been identified.

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

Requirement 3(3)(g)

Whilst minimisation of infection related risks through implementing standard and transmission-based precautions were found to be effective, the assessment team found that minimisation of infection related risks was not effective regarding appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. The assessment team brought forward:

* A pathology specimen was not collected or sent for pathology test prior to the prescribing and commencement of antibiotics for two consumers suspected infections.
* Two clinical staff were not familiar with the term antimicrobial stewardship and could not describe the strategies they utilise to minimise the use of antimicrobials.
* The monthly infection summary report did not show analysis of trending of the recorded infections, including eye infections.
* The service does not have an infection prevention and control lead.

The provider in their response provided clarifying and additional information, including:

* For one consumer, a pathology specimen was not able to be collected due to clinical reasons prior to the prescribing and commencement of antibiotics.
* The provider advised new clinical staff had been employed as the service is actively recruiting. A 2024 education schedule had been developed which include infection control and antimicrobial stewardship.
* The provider advised the information in the assessment team regarding monthly infection summary and eye infections were incorrect. Monthly infection summaries were submitted to evidence analyse and trending of recorded infections.
* Following recent clinical management structure change, a Clinical Nurse had been appointment to complete Infection Prevention and Control course. The provider submitted course enrolment evidence.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement:

* I place weight on the effective use of standard and transmission-based precautions to prevent and control infection. These include effective daily screening process to prevent respiratory infection and outbreaks, infection prevention strategies in place for other infections, appropriate personal protective equipment and hand hygiene practice by staff and having an outbreak management plan in place.
* For the two consumers who received antibiotics without pathology testing, I am satisfied the antibiotics were used for confirmed condition based on the consumers’ past health history, their presented clinical signs and symptoms and the medical professionals’ clinical assessments and judgements.
* In relation to the two clinical staff who were not familiar with the term ‘antimicrobial stewardship’, I consider this information alone without further clarifying details cannot be relied upon to establish overall staff understanding in minimising infection-related risks.
* I was persuaded that monthly infection summaries analysis and trend infections with required follow up actions detailed. A review of infection data submitted by the provider indicated a significant reduction in infection at the service.

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

# Standard 4

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

Findings

Consumers said they feel connected and engaged in meaningful activities that are satisfying to them. They confirmed the service acknowledges and observes their cultural and spiritual practices by supporting them to attend church services and celebrate specific days that are meaningful to their culture or religion. Consumers and representatives advised lifestyle staff are aware of their preferences, supports needs and staff make timely referrals to other individuals or organisations when required to meet their services and supports needs.

Whilst some consumers’ lifestyle goals are generic in nature and this had been considered under Requirement 2(3)(b), sampled care planning documents demonstrated each consumer had been assessed and is reviewed on a regular basis for their lifestyle and daily living needs. Lifestyle staff described how the tailored activity program is developed and adjusted based on consumers’ feedback. Documentation evidenced consumers are engaging in the lifestyle activity program and there are activities available to meet consumers’ individual spiritual needs.

Lifestyle staff indicated they encourage consumers to remain as independent as possible and participate in communities at the service or outside the organisation’s service environment. Care planning documents showed the service collaborates with external services such as allied health professionals, churches, spiritual leaders, and volunteers. Staff were observed providing consumers with emotional support and gave examples of how they have supported consumers who require additional and/or emotional support.

Sampled consumers confirmed they are provided with meal choices and the meals are nice. Staff described how they accommodate for consumers’ needs and preferences and how they seek feedback regarding menu changes. The provider collaborates with dieticians to review consumers’ nutritional intake, dining experience and quantity and quality of the food provided.

Equipment used for lifestyle activities and mobility aids were observed to be clean, well-maintained, readily used and stored appropriately. Maintenance records showed the service has a system in place for preventative and reactive maintenance requests, with all maintenance matters being addressed within acceptable timeframes.

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

# Standard 5

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

Findings

Consumers were satisfied with the standard of cleanliness and felt safe within the service environment. Representatives said the service environment is always well maintained and feels welcoming when they visit. Consumers and representatives advised furniture, fittings and equipment maintenance work are attended in a timely manner.

The service environment enables consumers to move freely both indoors and outdoors, interact with each other and be independent. Consumer rooms are located on the ground floor and the set up of consumer rooms and corridors support consumers to easily navigate their way around the service. Consumer rooms were observed with personal belongings and decorating items relevant to the consumer’s taste and lifestyle. There are communal spaces for consumers to socialise or participates in group activities. The garden areas were observed to be neat and tidy, with clean pathways free of debris.

Environment cleaning work was undertaken in line with a cleaning schedule which includes consumer rooms and communal areas. The service has preventative and reactive maintenance programs, as well as mechanisms for reporting of maintenance issues and potential hazards, to ensure a safe environment. Fittings and equipment such as electric beds and mobility aids were tested regularly to ensure they are in working order. Staff sanitise equipment regularly and between use and the equipment was observed in good condition and safe to use.

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

# Standard 6

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

Findings

Following non-compliance with Requirement 6(3)(c) found through the previous performance assessment contact conducted from 19 to 21 June 2023, the provider undertook multiple improvement actions to address deficits identified and the improvement actions were implemented successfully.

Consumers and representatives said they supported to provide feedback and complaints and felt encouraged to do so. They confirmed the service is prompt to make contact when things go wrong and would apologises or expresses regret at these times. Consumers and representatives felt complaints are managed well, addressed in a timely manner and have noticed improvements to care and services based on the feedback they have provided.

Feedback posters, forms and brochures, as well as written advocacy and language service brochures, were observed to be available at the entrance to the service, easily accessible to consumers and representatives. Management and staff encourage and support feedback mechanisms through an open-door policy, regular catchups with representatives when visiting, consumer and representative meeting forums, surveys and feedback forms. Staff are guided in the complaints management process by policies and procedures which outline open disclosure procedures and the use of advocacy and interpreter services when required.

The service has business processes to direct staff in ensuring feedback provided is identified, captured, actioned and reviewed. Feedback and complaints data evidenced the use of open disclosure principles in the management of all complaints, with apologies provided to the consumer or representative lodging the complaint and actions taken by the service to reach mutual agreements and/or prevent reoccurrence. Feedback and complaints data was reviewed monthly to identify any trends and opportunities for improvement, with trended data tabled at consumer and representative, staff, management and board meeting forums. Opportunities for improvement identified based on feedback data were observed to be reflected on the service's plan for continuous improvement log and either implemented or currently being actioned.

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

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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. | Compliant |

Findings

Following non-compliance with Requirements 7(3)(c), 7(3)(d) and 7(3)(e) found through the previous performance assessment contact conducted from 19 to 21 June 2023, the provider undertook multiple improvement actions to address deficits identified. Some of the improvement actions, specifically in relation to Requirement 7(3)(e), were implemented successfully.

However, I find Standard 7 Human resources non-compliant based on 2 of 5 of the specific Requirements have been found as non-compliant. These include Requirements 7(3)(c) and 7(3)(d). I have detailed reasons for my finding for each Requirement below.

Requirement 7(3)(a)

The assessment team were satisfied with the number and mix of members of the workforce deployed at the service. Consumers and representatives confirmed there are adequate numbers and mix of staff. They advised staff attend to consumers’ calls for assistance promptly, medications are provided within reasonable time limits and meals and lifestyle activities commence at scheduled times. Staff stated they have sufficient workforce to deliver care and services. The management team oversee a master roster and review staffing allocations daily to ensure staff skill mix meeting consumer needs and preferences. Staffing shortfalls were managed through backfilling with permanent and casual staff, extending shift times and utilising agency staff. Management stated they utilise data from clinical incidents, feedback and complaints to identify if changes to staff levels are required. Sufficient staff numbers were observed across all areas of care and services and staff did not appear to rush to provide care and services, maintaining a calm environment.

Whilst I am not persuaded that all care and services were delivered and managed safely and effectively, specifically in relation to some clinical care assessment, monitoring and evaluation, this has been considered and discussed under Standard 2 and Standard 3. I place weight on the positive feedback from consumers and representatives and the number and mix of workforce members are available to deliver care and services. I also place weight on the quality care and services delivered in other aspects such as consumer choice, personal care, lifestyle program, meal services, environmental maintenance and feedback and complaints.

Based on the evidence and reasons detailed above, I find Requirement 7(3)(a) compliant.

Requirement 7(3)(b)

The assessment team were satisfied with staff and consumer positive engagement and interactions. All consumers and representatives sampled confirmed staff interactions with consumers are kind, caring and respectful of their identity, culture and diversity. The staffing roster supports the consumer’s gender, diversity and preference needs and preferences. Staff members were knowledgeable of individual consumers’ unique qualities, culture, diversity and described how they adjust care to meet individual needs, such as the provision of gender specific or familiar staff. Staff also said they convey respect to consumers by using appropriate polite language and using consumers preferred names. Staff and consumers interactions during mealtimes and when specific consumers experienced changed behaviours were observed to be engaging, respectful and supportive.

Based on the evidence and reasons detailed above, I find Requirement 7(3)(b) compliant.

Requirement 7(3)(c)

The assessment team were not satisfied that the workforce is competent and have the knowledge to effectively perform their roles. The assessment team brought forward:

* Psychotropic medications used in the form of chemical restraint were not effectively identified by staff for 3 consumers. Subsequently these medication were not assessed, consented to and managed.
* Twelve clinical staff competency documents were incomplete and did not demonstrate if competence in the areas of assessment were achieved.
* Evidence listed under Standard 2 and Standard 3 showed a lack of staff knowledge and competence in relation to monitoring and management of consumers’ oral intake, fluid restrictions, pain, falls, medication, diabetes and following medical and health professionals’ direction.

The provider in their response acknowledged the deficits relating to 3 named consumer’s psychotropic medication and chemical restraint and advised a review had been completed. The provider advised the clinical competencies had been reviewed by the current management team and a total of 23 competency topics, for both registered and care staff, are scheduled for completion throughout of 2024.

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I was persuaded that clinical and care staff do not have the knowledge to effectively perform their roles to ensure safe and effective care delivery. I place weight on adverse outcomes for consumers highlighted in Standard 3 which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Whilst I acknowledge the provider’s response regarding psychotropic medication used for the 3 named consumers, I was not provided sufficient information to evidence the updated chemical restraint information is appropriate. In addition, although the service has monitoring mechanisms such as internal audit and regular reviews, the service’s current processes have not been effective in monitoring the workforce to ensure staff are sufficiently competent and knowledgeable.

The provider is planning to undertake improvement actions and I encourage them to implement and embed these improvements into their usual practice to ensure the clinical and care workforce is competent and have the knowledge to effectively perform their roles.

Based on the evidence and reasons detailed above, I find Requirement 7(3)(c) non-compliant.

Requirement 7(3)(d)

Whilst the workforce is recruited, the assessment team were not satisfied that staff are trained and supported to deliver the outcomes required by the Quality Standards. The assessment team brought forward:

* Not all clinical staff had completed all required mandatory training during their onboarding period.
* Multiple clinical care staff were unable to demonstrate appropriate level of knowledge in relation to identification of chemical restraint, monitoring and management of pain and behaviours, and reassessments following incidents and changed consumer conditions.
* Despite ongoing training sessions, including a range of topics relating to clinical care and documentation, had been provided, ineffective and unsafe work practices identified under Standard 2 and Standard 3 demonstrate the training has not been effective in ensuring the provision of safe and effective care.

The provider did not dispute the assessment team’s finding in their response. The provider’s response include commentary addressing aspects of the deficits as well as actions taken and planned in response to the deficits. The provider acknowledged incomplete mandatory training that was not identified nor followed up by previous management team and advised the current management team will monitor ongoingly. The provider stated they are aware of deficiencies relating to ineffective training and have developed an education schedule that will be delivered throughout 2024

In considering information from the assessment team report and the provider’s response relevant to this specific Requirement, I was not persuaded that the workforce is trained and supported to deliver safe and effective care and services. I acknowledge topics including restrictive practice, pain, behaviour, antimicrobial stewardship, medication, nutrition and hydration and diabetes have been included in the 2024 education schedule, however, I was not provided evidence to support how the provider will ensure the training delivered will be effective to support safe and effective care provision. Whilst I acknowledge the provider’s willingness to make improvements in relation to training and supporting staff to deliver outcomes required by the Quality Standards, these improvement actions are still requiring time to be implemented and embedded into usual practice.

Based on the evidence and reasons detailed above, I find Requirement 7(3)(d) non-compliant.

Requirement 7(3)(e)

The assessment team were not satisfied that assessment, monitoring and review of staff performance are effective in identifying deficits in clinical staff work practices. The assessment team brought forward that although some monitoring and review processes are effective, monitoring of progress notes and consumers’ clinical charting failed to effectively manage consumers’ care which have been highlighted in Standard 2 and Standard 3.

The provider in their response stated monitoring and mentoring of staff practices is continually being undertaken by the management team to ensure policy and procedures are followed. With the recently established management team in place, there has been a strong focus on staff performance to ensure that staff are aware of required expectations for care provision, clinical documentation and adhering to policy and procedures. Staff performances are now managed centralised, by a key management role, to ensure consistency and appropriate action is undertaken if staff performance concerns.

In considering relevant information from the assessment team report, the provider’s response, previous performance reports from 2023 and the provider’s self-assessment that was submitted in October 2023, I was persuaded regular assessment, monitoring and review of staff’s performance is undertaken based on:

* I have considered monitoring of progress notes and consumers’ clinical charting under relevant parts of Standards 2, 3 and 8.
* I rely upon consumers and representatives’ positive feedback relating to staff interaction, conduct and performance in many aspects of the care and services delivery, which have been evidenced in Standards 1, 4, 5, 6 and parts of Standards 2 and 3.
* I place weight on staff’s confirmation on their participation in probationary and annual performance appraisals where they can discuss their performance and identify areas for further training or support.
* I consider increased observation of staff practice and utilising performance appraisals completed to identify staff skill gaps and training plan an effective way to improve staff practice in care and service delivery.

Based on the evidence and reasons detailed above, I find Requirement 7(3)(e) 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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

Following non-compliance with Requirements 8(3)(c), 8(3)(d) and 8(3)(e) found through the previous performance assessment contact conducted from 19 to 21 June 2023, the provider undertook multiple improvement actions to address deficits identified.

However, I find Standard 8 Organisational governance non-compliant based on 4 of 5 of the specific Requirements have been found as non-compliant. These include Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). I have detailed reasons for my finding for each Requirement below.

Requirement 8(3)(a)

The assessment team were satisfied that the organisation has systems and processes in place, including a variety of consumer and representative engagement forums, to capture feedback and suggestions in the development, delivery and evaluation of care and services. Management, clinical, care and lifestyle staff described how they engage with consumers and representatives and support that engagement to gather feedback and suggestions, across a range of care and service topics, to ensure care and services are tailored to meet consumers’ needs and preferences. Consumers and representatives sampled confirmed they discuss care and services with management and staff, engage in development and review of care and services and are consulted on how care and services should be provided. Consumers and representatives also gave examples of their involvement in co-design care including initiating, evaluating and improving care and services at a system and process level.

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

Requirement 8(3)(b)

Whilst sampled consumers and representatives expressed satisfaction with care and services, the assessment team were not satisfied that the organisation’s governing body promotes a culture of inclusive, safe and quality care and services and is accountable for service delivery. The assessment team brought forward information relating to systems and processes to monitor consumer care delivery were not followed for a period of time due to instability in a senior management position, quality reports were not accurately reflecting all clinical areas including restrictive practice, deficiencies identified in Standard 2 and Standard 3 do not evidence a culture of safe and quality care is in place.

The provider’s response include commentary addressing aspects of the deficits as well as actions taken and planned in response to the deficits.

I have considered relevant information from the assessment team report, the provider’s response and the provider’s self-assessment that was submitted in October 2023 and I was persuaded that the organisation’s governing body promotes a culture of inclusiveness. However, I was not persuaded that the organisation’s governing body promotes a culture of safe and quality care.

* In relation to the inclusiveness, the assessment team did not bring forward information to evidence there was deficits. I place weight on that the organisation has an active diversity plan to support inclusiveness and to guide practice, including the development of a consumer advisory body. I also place weight on the evidence referenced in Standard 1, Standard 4 and Requirement 8(3)(a) which highlighted that consumers and representatives confirmation and satisfaction relating them being included in care and services initiation, planning, delivery and evaluation.
* In relation to the promotion of a cultural of safe and quality care, whilst the board is supposed to be involved in overseeing service management process including attending the service and to be continuously apprised of information from the service through relevant reports, such as clinical data reports and staffing issue reports, I was not provided with sufficient information to evidence how has the board used its observation and information received to improve the performance of the organisation against the Quality Standards, especially regarding the ongoing deficits identified in clinical care documentation and delivery, workforce knowledge and effective training, and organisational risk management and clinical framework.
* I acknowledge the governing body is actively taking improvement actions, including review and update the organisation’s strategic plan and workforce plan, develop a governing body skill mix matrix and review the processes regarding the suitability of key personnels. However, these improvement actions are still requiring time to be implemented and embedded into usual practice.

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

Requirement 8(3)(c)

The assessment team were satisfied with effective organisation wide governance systems relating to continuous improvement, finance and feedback and complaints. These were based on:

* The organisation has a continuous improvement framework with established processes to gather information from a range of sources to improve care and services including internal and external audits, feedback and complaints mechanisms, surveys and staff performance appraisals. Continuous improvement is discussed at various forums involving the board, management team, staff, consumers and representatives.
* Financial governance is overseen by the board that monitor and review organisational financial performance, income and expenditures, the maintenance and analysis of financial benchmarks and long-term investments. A board member is a registered accountant and the organisations finances are independently audited.
* The organisation has established feedback and complaints mechanisms that support the capture and analysis of feedback data, with reporting lines ensuring communication of any trending complaints or themes to the board.

The assessment team were not satisfied with effective organisation wide governance systems relating to information management, workforce governance and regulatory compliance. The assessment team brough forward:

* Although policies and procedures were developed and reviewed to ensure they are reflective of current best practice and regulatory and legislative requirements, the most current policies and procedures are not available to staff as the assessment team observed a folder of previous version of policies and procedures in the nurse station.
* Staff position descriptions and duty statements are being reviewed as the previous review was completed in 2012. Whilst the review process involved consultation between staff and management team to ensure the assignment of clear responsibilities and accountabilities, staff do not have access to the updated versions of these documents.
* Deficits identified in Standards 2 and 3 evidenced workforce governance being ineffective regarding monitoring staff practice to identify where shortfalls may exist and to ensure changes are made when a shortfall is identified.
* The organisation did not have a dedicated Infection Prevention and Control Lead which is a requirement for all residential aged care services.

The provider’s response did not agree with all of the assessment team’s finding and advised:

* The folder of previous version of policies and procedures had been removed. The folder with current policies and procedures were in the staff room for staff to access during the site audit.
* Staff position descriptions and duty statements are still being reviewed by the board.
* The management team is taking improvement actions to increase staff practice monitoring to ensure safe and effective clinical care delivery.
* Following a recent clinical management structure change, a Clinical Nurse had been appointment to complete Infection Prevention and Control course. The provider submitted course enrolment evidence.

In considering relevant information from the assessment team report and the provider’s response, I was persuaded the organisation has effective governance systems relating to continuous improvement, finance, regulatory compliance and feedback and complaints. In relation to regulatory compliance system, I place weight on information brough forward by the assessment team, specifically, the organisation has systems and process to track and respond to regulatory compliance changes, such as subscriptions to the Department of Health and Aged Care updates and memberships to peak industry bodies. Whilst the organisation does not have an Infection Prevention and Control Lead, I acknowledge staffing change over and am satisfied with the provider’s action in appointing a new Lead who will complete the specific course. I also place weight on the availability of an outbreak management plan and the effective infection prevention and control measure at the service, as described under Requirement 3(3)(g), that prevent and respond to infectious diseases whilst the current Lead completing the required course.

However, I was not persuaded the organisation has effective governance systems relating to information management and workforce governance.

* Regarding information management, in addition to the evidence brought forward by the assessment team, I place weight on evidence presented in other parts of the assessment team report and the provider response including clinical information documentation for multiple consumers have been inconsistent or incomplete; complete paper based monitoring records were not always locatable in a timely manner; clinical incidents data and quality data did not always capture accurate data to allow effective evaluation.
* Regarding workforce governance, in addition to unfinalised position description and duty statements, I note in other parts of the assessment team report and the provider response that not all staff have completed mandatory training during onboarding period; training delivered has not been effective in ensuring the provision of safe and effective care.

Although I acknowledge the provider is taking improvement actions for the deficits identified, these improvement actions are not fully completed and will require time to be embedded within the organisation’s usual processes and evaluated to ensure their effectiveness and sustainability.

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

Requirement 8(3)(d)

The assessment team were satisfied with effective risk management systems and practices in identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can. These were based on:

* Incident reporting policies, procedures and mandatory Serious Incident Report Scheme (SIRS) training guide and support staff practice. SIRS incident data including further actions required information are included in the quality reports which are provided to the board, management team and other relevant committees.
* The organisation has processes to identify and assess activities involving risks and staff are guided to supporting consumers to take risks with mitigating strategies in place. Policies and procedures are available to guide staff in the assessment of risks, with risk mitigating strategies discussed with consumers and representatives to ensure they make informed decisions.

The assessment team were not satisfied with effective risk management systems and practices in managing consumers’ care related high-impact or high-prevalence risks and managing and preventing incidents. The assessment team brough forward:

* Evidence included in Standards 2 and 3 regarding consumers’ high impact clinical risks were not managed effectively.
* Although the organisation has regular high-risk consumer meetings to discuss and evaluate consumers’ needs and management strategies, the meetings were observed to be not including all high-risk areas for the consumers.
* Whilst a system in place to collate, analyse and trend clinical incident data, not all medication incidents had been reported, or in a timely manner, to ensure accurate incident data and trending can be used to improve care and prevent further similar incidents.

The provider included clarifying and additional information in their response:

* The regular high-risk meetings were reimplemented recently following the appointment of the current management team. A full review of high-risk consumers’ care needs register were initiated as part of the continuous improvement actions. This register update had been completed in December 2023 to guide high-risk meetings.
* Relevant medication incident reports were completed during the site audit. The provider, as documented in other parts of their response, is actively taking improvement actions to address the issues identified.

In considering relevant information from the assessment team report and the provider’s response, I was persuaded the organisation did not have effective risk management systems and practices in relation to manage consumers’ care related high-impact or high-prevalence risks and use an incident management system to manage and prevent incidents. I relied upon evidence discussed under Standards 3 that consumers’ high impact or high prevalence risks were not managed effectively in relation to timely identification, assessment and monitoring of risks to their health, safety and well-being. These include the management of pain, fluid restriction, diabetes, deterioration, weight loss, medication, chemical restraint and behaviour support. I have also considered that the organisation’s own monitoring processes have not identified all the deficits identified by the assessment team relating to management of high impact or high prevalence risks to consumers’ care. I place weight on not all consumer incidents had been documented, escalated or reported in a timely fashion and in line with the organisation’s policy and procedures. I find this has not ensured that all incidents are identified or analysed to identify trends and opportunities for improvement to mitigate risks to consumers’ health and well-being or prevent further similar incidents.

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

Requirement 8(3)(e)

The assessment team brought forward that the organisation has a clinical governance framework in place. The framework includes information on antimicrobial stewardship, minimising the use of restraint and open disclosure. Whilst the assessment team were satisfied open disclosure principles were embedded into usual staff practice, the assessment team were not satisfied other parts of the framework being effective, based on:

* Evidence and deficiencies included in Standards 2 and 3 regarding in complete or inconsistent assessment and monitoring documentation, and ineffective management of consumers’ clinical needs relating to pain, fluid restriction, diabetes, deterioration, weight loss, medication, chemical restraint and behaviour support. These include, but are not limited to, not all chemical restraint had been identified, assessed or monitored; not all staff have a shared understanding of the meaning of antimicrobial stewardship; a lack of a current Infection Prevention and Control lead.
* Whilst the organisation has clinical care monitoring mechanisms, such as internal audits, high-risk consumer meetings, daily review of progress notes and monthly review of consumers’ monitoring charts, these mechanisms did not identify and remedy the clinical care delivery deficiencies or inconsistent or lack of appropriate staff knowledge in relation to these areas of clinical care delivery.

The provider in their response did not refute the assessment team’s finding and provided information and evidence on the improvement actions that had been completed and planned to be completed.

In considering relevant information from the assessment team report, the provider’s response including their Continuous Improvement Plan and the provider’s self-assessment information, I was not persuaded that the organisation has an effective clinical governance framework. I place weight on the systemic deficiencies in provision of multiple aspects of clinical care, evidenced in Standards 2 and 3. Whilst the existing framework had been recently reviewed and updated to include relevant information on monitoring and reporting, I find the framework is not effectively preventing, identifying, monitoring or addressing these systemic deficiencies and is not improving the quality of clinical care. Although I acknowledge the provider’s response, I was not provided with sufficient evidence to be persuaded that all the deficiencies identified had been addressed.

The provider expressed and evidenced their willingness to make improvements relating to effective clinical governance, including the reassignment of certain roles with specific monitoring duties, reimplement regular risk-based monitoring meetings, development audit tools and complete internal audits and other planned actions. However, these improvement actions have not been fully completed, will require time to be embedded within the organisation’s usual processes, and evaluated to ensure their effectiveness and sustainability.

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

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