Performance

Report

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| Name of service: | Performance report date: |
| St Basil’s Lakemba | 22 June 2022 |
| Commission ID: | Activity type: |
| 0098 | Site Audit |
| Approved provider: | Activity date: |
| St Basil’s Homes | 14 March to 15 March 2022 and – 03 May to 06 May 2022 |

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 St Basil’s Lakemba (**the service**) has been considered by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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.

**Note: The Site Audit was suspended from original visit of 14 March 2022, due to Covid-19 Outbreaks. The Assessment Team were on site 14 and 15 March 2022 and recommenced Site Audit 3 May to 6 May 2022.**

# Services included in this assessment

# Material relied on

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

* the Assessment Team’s report for the Site Audit, dated 18 May 2022; the Site Audit report was informed by a site assessment conducted 14 March to 15 March 2022 – 3 May to 6 May 2022, 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 02 June 2022
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: A total of 13 consumers and 23 consumer representatives were interviewed by the Assessment Team
* the following information received from the Secretary of the Department of Health (**the Secretary**): Exceptional Circumstances dated 15 September 2021.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-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 | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Requirement 1(3)(a) The approved provider must demonstrate that consumers are provided with resources to communicate in their own language, staff are responsive to call bells and provide required assistance to consumers for dignity and respect consumer’s personal or clinical care information.
* Requirement 1(3)(b) The approved provider must demonstrate that consumer’s care planning documents include the consumer’s cultural needs and how the service is meeting the traditions and preferences for them to live the best possible life they can.
* Requirement 1(3)(c) The approved provider must demonstrate there is a process for consumers to make decisions about their own care and the way care and services are delivered. Regular case conferences must be conducted with the consumer and representatives and others involved in their care.
* Requirement 1(3)(d) The approved provider must review dignity of risk forms for completion, with consent by consumer or representative, strategies to mitigate risk, evaluation of risk, review date and a risk rating according the service’s guidelines.
* Requirement 1(3)(f) The approved provider must ensure that consumer’s information is kept confidential and secured with their privacy respected.
* Requirement 2(3)(a) The approved provider must ensure consumers' care planning documents considers specific risks and reflects comprehensive assessment and planning for each consumer with risk assessment documented to prevent reoccurrence.
* Requirement 2(3)(b) Assessment and planning assessment and care plans reflect consumers' current individualised needs, goals and preferences. Assessment and planning are updated with change to consumer’s condition and end of life planning is in place for consumers.
* Requirement 2(3)(c) The approved provider demonstrates that assessment and planning is ongoing and completed in consultation with the consumer and their representatives when care plans are reviewed. The consumer must be assessed for cognition in their capacity with decision-making.
* 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. Case conferences are conducted with consumer and their representatives.
* Requirement 2(3)(e) The approved provider demonstrates that care and services are comprehensively reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. Recommendations from external specialists are documented in care plans.
* Requirement 3(3)(a) The approved provider must demonstrate that the identified deficits regarding consumer care are improved in the management of pain, wounds, behaviours and restrictive practices and follows best practice.
* Requirement 3(3)(b) The approved provider must ensure that high impact and high prevalence risks are identified with strategies implemented to reduce the risk occurring or reoccurring. Strategies must be reviewed and evaluated for effectiveness.
* Requirement 3(3)(c) The approved provider must demonstrate that consumers nearing the end of life are managed appropriately in relation to their end of life pain control, medication, skin and wound management and that palliative care plans are completed or updated to reflect the consumers' current care needs.
* Requirement 3(3)(d) The approved provider must demonstrate that a clinical assessment is conducted and escalated in a timely manner when a consumer’s condition suddenly declines with investigation to indicate how a consumer deteriorated in their clinical condition.
* Requirement 3(3)(e) The approved provider must demonstrate that information about consumers' conditions, needs and preferences is consistently communicated among staff and others where responsibility for care is shared and this information is documented and communicated appropriately.
* Requirement 3(3)(f) The approved provider must demonstrate that consumer’s requiring medical, specialist or allied health are referred in a timely manner.
* Requirement 3(3)(g) The approved provider must ensure that staff knowledge in infection control practices is demonstrated with PPE used appropriately and sanitiser available throughout the service.
* Requirement 4(3)(a) The approved provider must demonstrate that consumers are provided with appropriate emotional support and referrals to appropriate services when consumers would benefit and that consumers are provided with support to pursue activities of interest to them and always supported to maintain relationships of importance to them.
* Requirement 4(3)(b) The approved provider must demonstrate that there are meaningful activities provided to the consumers to promote their emotional, spiritual and psychological wellbeing. Assessment and care planning documents consumers’ lifestyle, cultural, spiritual and social needs
* Requirement 4(3)(c) The approved provider must demonstrate that management and staff always support consumers to participate in the community within and outside service, including engaging the consumers in activities of interest. Staff should actively communicate with consumers.
* Requirement 4(3)(d) The approved provider must ensure that information in care plans is accurate, completed, and communicated within the organisation and with others.
* Requirement 4(3)(e) The approved provider must ensure that networks for social services are available for consumers to access groups in the community outside the service for referral and psychological and emotional support is provided when required.
* Requirement 4(3)(f) The approved provider must demonstrate that consumers’ complaints and feedback in relation to food is considered for menu planning and catering staff receive training and have good knowledge of IDDSI.
* Requirement 5(3)(a) The approved provider must ensure that the service provides areas in the service that are quiet and provide wayfinding for consumers.
* Requirement 5(3)(b) The approved provider should ensure that the service is clean inside and out and that all maintenance is conducted including fire equipment.
* Requirement 5(3)(c) The approved provider must ensure that furniture, fittings and equipment are safe and well maintained. Equipment used for consumers must be high priority and serviced as per schedule.
* Requirement 6(3)(a) Then approved provider must ensure that consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints and action is taken when they raise concerns.
* Requirement 6(3)(c) The approved provider must demonstrate that complaints are investigated, and action is taken to resolve the issue. Remedial actions should be specific and include evaluation to ensure the actions were implemented or have been effective. Open disclosure should be understood and practiced by all staff.
* Requirement 6(3)(d) The approved provider must demonstrate that feedback and complaints are reviewed and documented in plan for continuous improvement and result in improvements to the quality of care and services.
* Requirement 7(3)(a) The approved provider must demonstrate that there are sufficient numbers of staff to enable the delivery and management of safe and quality care and services and that staff are responsive to consumers’ call bells in a timely manner.
* Requirement 7(3)(b) The approved provider must ensure that all staff are respectful, kind and caring in their interactions with consumers and representatives and staff understand the consumer’s identity, culture and diversity.
* Requirement 7(3)(c) The approved provider must ensure that the workforce is competent and agency staff are orientated and have the appropriate skills, knowledge and qualifications to perform their roles.
* Requirement 7(3)(d) The approved provider must ensure that all staff undertake mandatory training and regular updated training and that staff are supported to demonstrate their competency in a practical.
* Requirement 7(3)(e) The approved provider must ensure that regular assessment, monitoring and review of the performance of each staff member is conducted and that there is evidence of performance discussions, plans for improvement and monitoring of performance and outcomes.
* Requirement 8(3)(a) The organisation must demonstrate that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement The Assessment Team found that consumers are not supported to be engaged in the development, delivery and evaluation of care and services and to partner in their care. Resident meetings include feedback from consumers and representatives and are documented and actioned in plan for continuous improvement. Regular consumer surveys are conducted to inform the care and services.
* Requirement 8(3)(b) The organisation’s governing body responds appropriately to the deficiencies identified across all the Quality Standards to promote a culture of safe, inclusive and quality care and services and be accountable for their delivery.
* Requirement 8(3)(c) The approved provider must demonstrate that there is an effective organisation wide governance system relating to information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints.
* Requirement 8(3)(d) The approved provider must demonstrate that the risk management systems and practices, are effective in managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can; recording, investigating, managing and preventing incidents, within an incident management system.
* Requirement 8(3)(e) The approved provider must demonstrate that the clinical governance framework is effective in the management of antimicrobial stewardship; minimising the use of restraint; and open disclosure.

# Standard 1

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| Consumer dignity and choice | | Non-compliant |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Non-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. | Non-compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-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. | Non-compliant |

## Findings

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

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

The Assessment Team received mixed feedback from consumers and representatives regarding this requirement. Whilst several consumers felt they were treated with respect, others provided feedback about experiences which are not respectful or dignified. One consumer who does not speak English is unable to speak with non-Greek speaking staff as there are no communication aids to enable the consumer to communicate. The Assessment Team also identified for one consumer that staff are not aware of the consumer’s social, cultural and spiritual needs although the consumer has resided at the service since 2016.

One consumer and representative advised the Assessment Team that consumers call out for assistance and use their call bell, and no one comes, or someone comes and says to wait, and they will come back, and they don’t, this results in the consumers having accidents, which is undignified and disrespectful.

The Assessment Team observed staff calling to each other across the lounge area in Olive Grove and asking each other whether consumers had opened their bowels that day.

The approved provider responded to the Assessment Team’s report however, did not respond to the matters raised above.

Accordingly, I find requirement 1(3)(a) each consumer is treated with dignity and respect, with their identity, culture and diversity valued is not-compliant.

**Care and services are culturally safe**

The Assessment Team found that most consumers at the service are of Greek background with three consumers that are either Italian, Bangladeshi or Australian/Irish decent. There is minimal information in their care planning documents regarding their cultural needs and how the service is meeting the traditions and preferences for them to live the best possible life they can.

The Assessment Team found for one non-English-speaking consumer, the care plan states that Greek cultural background has been a very important part of the consumer’s life. It states that due to cognitive decline the consumer is unable to comprehend cultural needs of the past but cultural celebrations and individual cultural support is still provided. The care plan does not include any information about how the consumer’s cultural needs will be met, other than celebrate all holidays in Greek Orthodox calendar.

The approved provider responded to the Assessment Team’s report however did not respond to the matters raised above.

Accordingly, I find requirement 1(3)(b)care and services are culturally safe is not-compliant.

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

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

The Assessment Team found that consumers are provided with limited choices to exercise and maintain independence relating to decision making and their choices are not always supported. There is no process to identify how consumers make decisions about their own care and the way care and services are delivered; or how they make decisions about when family, friends, carers or others should be involved in their care and communicate their decisions.

The Assessment Team found that the service has not been conducting regular case conferences although has recently introduced a schedule for regular case conferences to occur. Currently seven case conferences have been completed.

Several representatives complained that they were unable to visit consumers during the outbreak even though they were providing daily care for them. The service has not commenced a Partners in Care program to support consumers with care and companionship when needed. From June 2022 the organisation plans to restrict visitors if they do not have a third COVID-19 booster. It was noted for one consumer who was declining, the family was not given permission to visit and were not able to see their consumer before passing.

Staff were able to provide some examples of how they support consumers to make informed choice and maintain their independence, but this was not always observed in practice. The Assessment Team observed consumers in Olive Grove are unable to move freely into the external courtyard as the door was often locked. The service does not demonstrate understanding of the concepts of substitute decision making and Medical Officers have been making decisions about consumers’ clinical care as documented in consumer outcome statements for two consumers.

The approved provider responded to the Assessment Team’s report and provided information that the Guardianship Board had advised that the Medical Officer could be the substitute decision maker.

Accordingly, I find requirement 1(3)(c)each consumer is supported to exercise choice and independence, including to; make decisions about their own care and the way care and services are delivered; and make decisions about when family, friends, carers or others should be involved in their care; and communicate their decisions; and make connections with others and maintain relationships of choice, including intimate relationships is not-compliant.

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

The Assessment Team found that consumers are not always supported to take risks to live the best life they can. Although there are some risk assessments, the assessments are not used to mitigate risk to consumers to support their choices and preferences.

The Assessment Team reviewed the service’s new dignity of risk register which did not match up with consumers identified in the service’s electronic consumer record system as having dignity of risk assessed. The general manager confirmed that the process for updating consumer records with dignity of risk information was still ongoing and not complete.

Dignity of risk forms reviewed were incomplete regarding some items including consent by consumer or representative, strategies to mitigate risk, evaluation of risk, review date and a risk rating according the service’s guidelines. Risk assessments and strategies to mitigate risk for three smokers at the service were mainly generic, such as must be supervised and to wear a protective apron.

The approved provider responded to the Assessment Team’s report and furnished a copy of the Risk Policy and Process training records, however did not provide further information about identifying risk and risk strategies to enable the enable the consumer to live the best life they could.

Accordingly, I find requirement 1(3)(d) each consumer is supported to take risks to enable them to live the best life they can is not-compliant.

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

The Assessment Team identified that information is not always provided to each consumer in a way that is clear or timely and enables them to exercise choice. There is inconsistency in the information being translated for use by consumers and representatives such as complaints posters, relative meeting minutes and consumer agreements, where some are in Greek, some in English and some in both Greek and English.

The Assessment Team interviewed consumers and representatives and found that they are not provided with a copy of their care plan and some are not aware of a consumer care plan. Several representatives said they have not had a case conference with management and do not have a copy of the consumer’s care plan.A representative said they don’t get much communication from the service. They didn’t know for quite a while that there was a new management team.

Another representative complained that information about the COVID-19 outbreaks were not provided to them in a timely manner.

The approved provider responded to the Assessment Team’s report and furnished examples of correspondence sent to representatives in relation to the Covid-19 Outbreaks and communication advising of the new General Manager.

I have considered the approved providers response and information provided and find that the approved provider is compliant with this 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.

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

The Assessment Team observed consumers information is not being kept confidential and consumers privacy is not respected. The team observed that shared rooms with a privacy partition do not provide consumers with privacy when in discussion with staff or representatives. The Team also found consumer notes left throughout the day on a table in a common sitting room in Lourantos Village including when staff were not there. Registered nurses use a small desk in the lounge rooms as their office area in Lourentos Village. The desk has a computer and was noted to have several consumers documents and handover sheets. The area is within the lounge room and consumers were sitting nearby. The Assessment Team identified the registered nurses are unable to ensure confidentiality when discussing care needs with other staff members and documents are not secure but stored on the desk. The management team said there is no other available space for the registered nurses to have a suitable office area.

The Assessment Team identified the clinical office doors left open and no staff in attendance over the 4-day site audit. The handover sheet at the level 2 nurses' station in the nursing home is kept on the top of the counter which enables anyone coming to the nurses’ station to read consumers’ information. There was a list of consumers who were on food and fluid charts on the wall near the desk in the dining room of level 2 of the nursing home.

The approved provider responded to the Assessment Team’s report however, did not respond to the matters raised above.

Accordingly, I find requirement 1(3)(f)each consumer’s privacy is respected and personal information is kept confidential is not-compliant.

# Standard 2

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

## Findings

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

**Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.**

The Assessment Team interviewed consumers and representatives who mostly did not consider that they feel like partners in the ongoing assessment and planning of their care and services. A review of the sampled consumers' care planning documents does not always consider specific risks or reflect comprehensive assessment and planning for each consumer. Registered nurses are responsible for consumer assessments and to identify the consumer’s risks associated with their care and direct safe and effective care. However, inconsistencies were identified in the sampled consumers' care planning documents.

The Assessment Team reviewed the service's polypharmacy report from 1 April 2021 to 30 April 2022, which shows that about 82/93 consumers were on 10 or more polypharmacy medications; it noted that 0/93 consumers had a Residential Medication Management Reviews (RMMR) completed at the time of the site audit to identify risks associated with polypharmacy medication use and with the view “to try to reduce unnecessary medication use”.

The Assessment Team noted for the consumers sampled that there is minimal risk assessment with interventions not reviewed to prevent reoccurrence.

The approved provider responded to the Assessment Team’s report and furnished a care plan for one consumer; however, it did not identify the risks that were identified by the team in relation to the increased rate of oxygen and the risks associated with the use of oxygen.

Accordingly, I find 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 is not-compliant.

**Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.**

The Assessment Team reviewed care plans and noted that while assessment and care plans are completed, they do not reflect consumers' current needs and goals. The goals in the consumers' care plans were noted to be generic and the same goals of care as other consumers and not individualised for each consumer. Care planning documentation does not routinely record or address consumers' current needs, goals and preferences and for one consumer had not been updated since 2019, following a new diagnosis.

The Assessment Team did not identify that end of life planning was in place for all consumers. For some consumers, the palliative care plan is not completed or updated to reflect the consumers' current care needs, and the service does not use the end of life pathway document to closely monitor the consumers' care.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find 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 is not-compliant.

**The organisation demonstrates that assessment and planning:**

**(i) 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**

**(ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.**

The Assessment Team reviewed assessment and care plan documentation which identified minimal or no documentation to indicate that there is ongoing consultation with the consumer and their representatives when care plans are reviewed. Deficits are identified in assessing the capacity or cognition of consumers in decision-making.

The Assessment Team interviewed consumers and their representatives with one consumer adamantly stating that he does not feel like a partner in his care as he is not informed about his care and what is happening. One representative provided feedback that he is not involved in his partner’s care planning; "no one talks to me about care; I do not know anyone to talk to about her care".

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 2(3)(c) the organisation demonstrates that assessment and planning; 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 includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer is not-compliant.

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

The Assessment Team interviewed consumers and representatives who explained that while they are informed when the consumer’s condition changes or an incident occurs, three consumers and 13 representatives said they do not have a copy of their care plan, and it is not discussed with them. A review of consumers’ care and services records did not show that the assessment and care planning outcomes were communicated to consumers or their representatives. All representatives sampled said they had not had any care conferences. When raised with the management team, the care manager said they have only been able to attend four out of 134 care conferences so far.

A representative told the Assessment Team about an incident in which a staff member had asked the doctor to refer their family member to psycho-geriatrician without first discussing this with the consumer or representative. When the representative complained to the staff member about this action being taken without discussion with the consumer or representative, they told the representative that this was a standard practice every two years for all consumers. There was no reason the consumer should have been referred to a psycho-geriatrician and the doctor immediately said that is not necessary.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find 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 is not-compliant.

**Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer**.

The Assessment Team reviewed care plans and found that while care plans are generally reviewed following incidents, consumers' goals are not consistently reviewed when their condition or needs change. Comprehensive review of care plans is not conducted regularly or immediately post incident. Care plans are also not reflective of the changes when circumstances change, or incidents occur.

Some care plans reviewed by the Assessment Team were not accurate reflections of the outcomes of assessment and planning as the care and service plan did not corroborate information following a review from the external specialists.

The Assessment Team found that for two consumers, recommendations from Dementia Services Australia have not been documented or followed up despite being referred for behaviour management.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find 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 is not-compliant.

# Standard 3

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

## Findings

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

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

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

The Assessment Team identified that the service has ineffective personal care and clinical governance in place to ensure each consumer is receiving care that is best practice, tailored to their needs and optimising their health and well-being. A review of documentation, feedback from consumers, representatives and staff, and the Assessment Team’s observations of the service identified deficits regarding consumer care not being met in the management of pain, wound and restrictive practices.

The Assessment Team reviewed assessment and care plans and found wound care was deficient for one sampled consumer with wound charts showing that wound care and pain management was not followed as directed by wound specialist. The Assessment Team also identified that observation charts show inconsistencies in recording the neurological observation as per the service’s falls management policy and procedure. The Assessment Team identified for consumers demonstrating behaviours, the review of incidents shows that follow up post incidents do not occur as per the service’s behaviour management policy and procedure. Pain assessment and pain charts have not been commenced following incidents, delirium screening is not always conducted, and the effectiveness of behaviour management strategies have not been evaluated to deem it effective post each incident. There was little evidence to support that triggers for behaviour were identified.

The Assessment Team spoke to clinical staff about behaviour triggers and how they ensure the strategies are evaluated, they said they do not have to evaluate the strategies as they are only document them when the strategies are deemed effective.

The Assessment Team reviewed the service's restrictive practise register and noted inconsistencies where staff have not regularly updated the restraint authorisation form as required. While some consumers have their review/consent authorisation form signed and completed by the medical officer or their representative as required, others do not have updated authorisation.

The approved provider responded to the Assessment Team’s report and provided feedback that the wound care was followed as directed, and observations were conducted following a consumer’s fall. However, the provider did not address responding to behaviours of concern, how they identify triggers, and manage behaviours including the evaluation of strategies to prevent incidents from reoccurring.

Accordingly, I find requirement 3(3)(a) each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being is not-compliant.

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

The Assessment Team reviewed care plans and found that there is a lack of clinical oversight in the management of care for consumers with high impact or high prevalence risks. Deficits were identified in the management of consumers with a range of specialised care needs, including tracheostomy care, diabetes, neurological observations, skin care, falls, behaviours, and medication management. The Assessment Team identified inconsistent reporting, and monitoring charts were not routinely completed as directed.

The Assessment Team observed unlocked medication trolleys in the hallway with no registered nurses or staff surveillance. Clinical staff were observed to dispense schedule eight (S8) medication without following medication management policy and practice. Staff were observed crushing medication for all consumers while assisting them with medication lubricant (gloup) in the afternoon. The staff member also dispensed medication without a medication chart or the electronic medication chart (iPad). When asked about it, the staff said they know the consumers and can identify them. The Assessment Team found the level 1 medication room to be open with the medication trolley left unlocked with no staff present and on another two occasions the treatment room/nurses’ station in Olive Grove was left unattended and unlocked with a range of medications accessible.

The Assessment Team identified that for consumers at risk of falls, there is no follow up, reassessment, minimal investigation of the cause of the incident, and how to minimise a re-occurrence. There were no mobility assessments to inform care plans or changes in care plan.

The approved provider responded to the Assessment Team’s report and provided a training spreadsheet from 2021 for Tracheostomy Management, however it is unclear if the named staff are still working at the service or if other clinical staff have been trained. A spreadsheet for High Impact and High Prevalence Risk training was also provided where 75/77 named staff completed this training following the Site Audit. Care Plan notes of named consumers were also provided, however this did not persuade me that the service manages high impact and high prevalence risks effectively.

Accordingly, I find requirement 3(3)(b) effective management of high impact or high prevalence risks associated with the care of each consumer is not-compliant.

**The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.**

The Assessment Team found that the service is unable to demonstrate that consumers nearing the end of life are managed appropriately. A review of consumers' documentation and interviews with representatives identify that the needs of some consumers have not been well managed. The sampled consumer documentation that was reviewed showed deficiencies in the management of their end of life pain control, medication, skin and wound management. For some consumers, the palliative care plan is not completed or updated to reflect the consumers' current care needs, and the service does not use the end of life pathway document to closely monitor the consumers' care.

The Assessment Team noted for one consumer that recommendations from the palliative care and complex pain management services (PACCs) clinical nurse consultant (CNC) for the commencement of a palliative pathway had not been followed. Gaps and inconsistencies were evident for other consumers deteriorating and reaching end of life with no information documenting pressure care and gaps in pain monitoring and assessment.

The approved provider responded to the Assessment Team’s report and furnished information, however did not information that specifically addressed this requirement.

Accordingly, I find 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 is not-compliant.

**Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.**

The Assessment Team found the service is unable to demonstrate appropriate management has occurred for consumers when their condition has deteriorated. The monitoring of consumers' health status after incidents and when their health has deteriorated was identified by the Assessment Team to be not consistent with the service’s policies and best practice guidelines.

The Assessment Team reviewed records for sampled consumers and identified deficiencies which consist of a lack of clinical assessment when a consumer’s condition suddenly declines, wound care not being managed appropriately and escalated in a timely manner and a delay in notifying and allowing a consumer’s family to visit when the consumer declined and minimal progress entries to indicate how a consumer deteriorated in their clinical condition.

The approved provider responded to the Assessment Team’s report and furnished a copy of one consumer’s wound care plan and training records on deterioration; however, this did not persuade me that the service managed the change and deterioration to a consumer’s condition in a timely manner.

Accordingly, I find 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 is not-compliant.

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

The Assessment Team reviewed documentation and conducted interviews with consumers, representatives and staff which showed that information about consumers' conditions, needs and preferences is not consistently communicated among staff and others where responsibility for care is shared. Deficits were identified with a variety of documents, for example, handover sheets and consumers' room numbers not accurate, specialist reports and recommendations not in progress notes entries and care plans and inconsistent care plan information.

The Assessment Team interviewed management who advised that issues had been identified in relation to communication between lifestyle and clinical staff and they are working to address this. The plan for continuous improvement has an entry added on 16 November 2022 that “life story assessment on Lee Care is not consistently reflective of the resident’s history, needs, goals and preferences”. It was noted for one consumer who was to commence on the palliative pathway, the recommendations from palliative care and complex management services were not followed for the consumer and staff were unaware of the rate of oxygen being given.

The Assessment Team spoke with a representative who said the lack of, and inconsistent, communication with registered nurses is a problem and should be improved.

The approved provider responded to the Assessment Team’s report however did not produce evidence to support their compliance in this requirement.

Accordingly, I find 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 is not-compliant.

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

The Assessment Team identified that for some consumers' appropriate and timely referral process has not occurred to meet their needs.

The Assessment Team interviewed consumers and representatives who provided feedback, with one consumer stating that they had been waiting to see a specialist for some time and nothing happens, and no one follows it up. A Serious Incident Response Scheme (SIRS) report was made to the Commission in January 2022, with the service advising the Commission that a consumer would be referred to a physiotherapist and occupational therapist for a multi-disciplinary approach to falls management however these referrals have not been actioned. The Assessment Team also noted that staff had been seeking support from management to refer a consumer to the Older Person’s Advocacy Network (OPAN), but it had not happened.

The approved provider responded to the Assessment Team’s report however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 3(3)(f) timely and appropriate referrals to individuals, other organisations and providers of other care and services is not-compliant.

**Minimisation of infection related risks through implementing:**

1. **standard and transmission-based precautions to prevent and control infection; and**
2. **practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.**

The Assessment Team reviewed documentation, obtained feedback from staff and undertook observations of staff practices which showed a lack of standard and transmission-based precautions are in place to prevent and control infections. Although some staff have a good understanding of antimicrobial stewardship, many did not, and this included registered nurses. Feedback was that they could not remember having any training on the subject. A review of the COVID -19 outbreak management plan shows it is outdated and not reflective of current NSW Health guidelines.

The Assessment Team interviewed clinical staff who advised they were the infection control leads at the service, although they have not completed the training. The current outbreak plan identifies that most documents are not current and up to date and would be of minimal guidance if an outbreak were to occur.

The Assessment Team requested COVID-19 vaccination numbers for consumers and staff, although this was not provided. The staff education records show only 20 staff members had donning and doffing education during the recent outbreak in March 2022. No other staff members completed infection control education and competencies during this timeframe to ensure the consumers were safe.

Deficits identified by the Assessment Team regarding staff practices in standard and transmission-based precautions were observed throughout the site audit. Interviews with staff identify a lack of knowledge in infection control practices. The Assessment Team observed staff to be wearing their mask below their chin, staff were observed cleaning rooms and not removing their gloves and using hand sanitiser after each use, before entering other consumers rooms with the same gloves on. There are no sanitising wipes or hand sanitisers near computers or phones and minimal near entry/exit doors throughout the service. The service has water coolers in use, although there are no sanitisers wipes located near the machines or no extra cleaning in place. Although the service has policies in place antimicrobial stewardship, staff were not knowledgeable about this; with 11 staff who were interviewed not knowing what the term means. They said they could not remember having any education on the topic.

The approved provider responded to the Assessment Team’s report advising that they have scheduled anti-microbial training for June 2022, the service also advised that have 61 completions of either infection control education or competencies during March 2022, however observations did not demonstrate that staff had a good understanding in practice. The IPC Leads have now completed their training. The service provided a copy of the line list; however, this did not have all data completed for staff and consumers vaccination.

I find that the approved provider is not-compliant with this requirement 3(3)(g) as the service does not demonstrate that there is minimisation of infection related risks through implementing: standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Non-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. | Non-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. | Non-compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

## Findings

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

**Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.**

The Assessment Team identified consumers do not receive safe and effective services and support for daily living which meet their needs, goals and preferences and optimises their independence, health, well-being and quality of life. The service has not ensured that consumers are treated with dignity and respect.

The Assessment Team interviewed consumers and their representatives who identified that there are limitations in consumers being able to exercise choice. Consumers are not provided with appropriate emotional support and referrals to appropriate services are not made when consumers would benefit. Some consumers are not provided with support to pursue activities of interest to them and they are not always supported to maintain relationships of importance to them. Some consumers are not satisfied with the meals provided and do not enjoy a quality dining experience. Consumers expressed dissatisfaction with aspects of care and service but do not have their concerns effectively responded to. One consumer provided feedback that there is limited communication when the staff provide personal care or meals. The consumer said the staff are “kind and caring; but they don’t talk to me.” The consumer expressed dissatisfaction with the meals and said the staff “must be busy they have to look after so many and they can’t meet everyone needs I understand; somedays I feel we are all waiting for god to take us in here”. When asked about having things to do that are of interest to them, they said they did not like the activities that were offered; “they ask me for this and that, but I don’t like it. If you are quiet and don’t complain about anything girls will like you and I don’t want to be in their bad list. So, I don’t have any complaints”. The consumer expressed that if staff are unhappy with a consumer it shows in their faces and said “We are old, and everyone will be one day. Being young makes you strong not kind”.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find 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 is not-compliant.

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

The Assessment Team found that there are limited meaningful activities provided to the consumers to promote their emotional, spiritual and psychological wellbeing.

The Assessment Team interviewed Lifestyle staff who said they undertake assessments in relation to consumers’ lifestyle, cultural, spiritual and social needs. This includes in relation to supporting relationships and intimacy. Emotional and psychological needs assessments are largely undertaken by registered nurses, but the lifestyle staff have input into the assessments. They said there have been issues in relation to the clinical documentation system which gathers limited information to inform assessments and key information about consumers’ needs and does not populate appropriate interventions to various sections of the care plans.

The Assessment Team also observed that the service does not ensure a quality dining experience for consumers. There are almost no tables and chairs in the level 2 nursing home dining room. The tables and chairs that are in the dining room are not set up in a manner that supports a dining experience and the overall atmosphere of the room is bare and uninviting. Almost all consumers in the level 2 section of the nursing home are served their meals in their rooms. Staff said consumers don't use the activity/dining room and are kept in the lounge area instead because it is easier for them to be supervised in the lounge area.

Staff were repeatedly observed standing over consumers when assisting them with their meals.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 4(3)(b) services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being is not-compliant.

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

**participate in their community within and outside the organisation’s service environment; and**

**have social and personal relationships; and**

**do the things of interest to them.**

The Assessment Team found that aspects of the service and staff practices do not always support consumers to participate in the community within and outside service. Practices do not always support consumers’ relationships, and consumers who are unable, or uninterested, in group activities are not supported to pursue activities of interest to them. The Assessment Team observed staff sitting on a four-wheel walker without engaging with consumers, when asked what was happening for the consumers the staff member said she was to watch the consumers.

The Assessment Team observed that many consumers are left in their bedrooms throughout the day. The Assessment Team interviewed consumers and their representatives and received feedback confirming that consumers are not provided support to leave their bedroom and go outside.

The Assessment Team interviewed staff who said that agency staff are reluctant to transfer consumers to chairs and to encourage consumers to be out of their rooms. In addition, there generally aren't enough care staff around to transfer consumers; it is an issue that staff are constantly dealing with. They said while consumers used to always come out of their rooms, it now seems as if staff have become used to leaving consumers in their bedrooms; it has become the norm. Staff said bus trips occur twice a week for consumers in the general areas of the service. Bus trips for consumers living in Olive Grove (memory support unit) only occur every fortnight. Since bus trips were recommended in February 2022, consumers have not been allowed to get off the bus during bus trips. The staff said consumers really want to be able to get off the bus (including going to the toilet) but there has been a directive from the organisation that this should not occur and that it has not yet been decided if it is safe for consumers to get off the bus during bus trips.

Management of the service advised the Assessment Team the service does not have a Partners in Care program and explained that the organisation intends to develop a Partners in Care program in the future. However, when the new management teams commenced, it was not considered a priority given that issues of clinical safety were evident and a greater priority. There are no entries on the plan for continuous improvement regarding the introduction of a partners in care program.

The Assessment Team discussed a letter sent to families advising them that from 1 June 2022 all visitors will be required to show evidence that they had received a third COVID-19 vaccination. The chief executive officer said the organisation is aware that this is not an NSW Health order requirement. However, the organisation has decided this action is required to ensure the safety of consumers.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 4(3)(c) services and supports for daily living assist each consumer to: participate in their community within and outside the organisation’s service environment; and have social and personal relationships; and do the things of interest to them is not-compliant.

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

The Assessment Team found that the service does not have effective systems to ensure that information about the consumer’s condition, needs and preferences in are communicated effectively. It was identified that not all agency staff have access to care plans.

The Assessment Team identified gaps in assessment and care planning with of consumers’ lifestyle, cultural and spiritual needs and preferences and lack of information about how any identified needs are met. There is conflicting information in care plans and parts of the care plans are not completed, this impacts on the consumers’ needs and preferences being accurate and communicated within the organisation and with others.

The Assessment Team identified there are deficiencies in information sharing in relation to consumer’s clinical needs for oxygen administration, staff not aware of consumer’s dietary requirements and staff practices in food service.

Risks are not identified or informed to develop new strategies to prevent reoccurrence of incidents, and there is a lack of communication to families in relation to their consumer deteriorating.

The approved provider responded to the Assessment Team’s report and provided information about one consumer’s dietary needs and food safety records for Hotel staff, however this did not address or persuade me that this requirement was compliant.

Accordingly, I find 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 is not-compliant.

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

The Assessment Team did not find evidence that the service ensures that referrals to appropriate individuals, services and providers of care occurs. The Assessment Team noted that there have been no referrals for emotional support for consumers that require additional counselling following the loss of a loved one. There have been no referrals to OPAN for a consumer to access emotional and psychological support. There does not appear to be networks for consumers to access to groups in the community outside the service.

The Assessment Team spoke with consumers and staff who advised that there are currently no external social services such as Community Visitors Scheme to support consumers to connect with their cultural lifestyle.

The approved provider responded to the Assessment Team’s report however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 4(3)(e) timely and appropriate referrals to individuals, other organisations and providers of other care and services is not-compliant.

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

The Assessment Team interviewed consumers and representatives who mostly indicated they were satisfied with the quality and quantity of meals. However, some consumers raised some concerns. Feedback from dissatisfied consumers included that the food is hard to eat, and the representative brings food in and leaves in the fridge for the consumer to have something when the food is not edible. Three consumers said the food is terrible, quality poor, cooked badly and is mostly cold. One consumer added that nobody likes the food and there is not enough Greek food. A representative said their family member dislikes the meals, and they have complained lots of times, but nothing happens; even the Greek dishes are not cooked properly.

The Assessment Team found that the menu provides choices for meals, however the service does not have a system to enable consumers to choose their meals. Catering staff said that in the past consumers were asked the day before what choice of meal they wanted the next day. It was determined that this was taking too long and so it was decided that consumers would be asked at the time the meals are served from the bain-marie in the dining rooms.

The Assessment Team observed consumers were served their entire lunch meals in take away food containers using disposable cutlery and were served ‘popper’ style drinks. Catering staff in the servery said that they were working short that day. The meals were all plated into the plastic, and in some cases aluminium containers, and placed on individual consumer trays without any mechanism to keep the meals warm until they were served.

The Assessment Team observed some dietary preferences are listed on a whiteboard in the main kitchen, but many are not listed. The catering supervisor said there had been no education for catering staff about IDDSI (International Dysphagia Diet Standardisation Initiative) and preparation of texture modified meals for a long time; possible several years.

The approved provider responded to the Assessment Team’s report and provided a record of Hotel staff that had completed food safety training and provided information about one consumer’s dietary needs. The provider advised a new position has been created by St Basil's to oversee all hotel services, including catering. The Group Manager Corporate Services will work with the Lakemba chef to ensure the correct systems and processes are in place to ensure consumer satisfaction and safety.

I acknowledge the improvements that the provider is initiating, however realise this will take some time to reflect changes to this requirement. I therefore find that this requirement 4(3)(f) where meals are provided, they are varied and of suitable quality and quantity is not-compliant.

# Standard 5

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

## Findings

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

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

The Assessment Team found the communal consumer areas are also used as staff work areas with no separation between the staff area and consumer living areas. Staff desks were placed in the main lounge area in Lourantos and in the east/west wing of the nursing home. The level two section of the nursing home does not have an inviting lounge area; it is an area combined with the dining room and is not arranged to create an inviting area to sit and relax. There is also a staff desk in this area. The staff desks have a range of work information and some had consumers’ personal information taped to the wall and on the desk. Some staff work instruction signs were also on the wall of the desk in Lourantos. Staff were conducting meetings, including with the Assessment Team, at the staff desk in Lourantos.

The Assessment Team found that the communal areas in most sections of the service are very loud. In Lourantos there are some small quieter areas throughout the wing. However, most consumers are gathered into the noisy lounge area or remained in their bedrooms.

Management acknowledged that communal areas are sometimes noisy and that there are issues with wayfinding. Management acknowledged there are issues with the design and maintenance of the service environment and showed the Assessment Team a plan which has been developed to revamp the east/west wing area.

The approved provider responded to the Assessment Team’s report and advised that they have invested a considerable budget to upgrade the main dining and lounge area with new furniture purchased for Lourantos Village. The approved provider advised that an independent review has been conducted of St Basil's Hotel Services (Catering, Cleaning, Laundry) and completed by PWC. Multiple recommendations have been made and are in varying stages of implementation. St Basil's are acutely aware of the importance of the Hotel Services and a review of existing operations has commenced with a single point of oversight.

I acknowledge the work that the service is implementing, however find that there is considerable work to be completed for the service to provide an environment that is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. I find that the approved provider is not-compliant with this requirement 5(3)(a).

**The service environment:**

**(i) is safe, clean, well maintained and comfortable; and**

**(ii) enables consumers to move freely, both indoors and outdoors.**

The Assessment Team found that Consumers living in Olive Grove are unable to freely access outdoor areas. All doors have keypad locks which cannot be opened by consumers. Except for several short periods when staff took consumers out to the courtyard, the doors were kept closed throughout the site audit. Some consumers were observed shaking the handles to the courtyard areas of Olive Grove. Staff said consumers do not have access to the courtyard area because it is too hard for them to be supervised.

The Assessment Team identified there is a smoking gazebo in the middle of the grass area outside Lourantos wing. It is only accessible across an uneven grass area which poses a fall hazard to consumers. The smoking area was dirty and there were no ashtrays. A fire extinguisher was installed. Maintenance staff said they had recently been requested to make the gazebo into a smoking area; no risk assessments were undertaken regarding the safety and suitability of access to gazebo and the gazebo itself. Many aspects of the service environment were dirty and poorly maintained including outdoor areas. Paved areas were covered in leaves, dirty marks and had not been cleaned for extended periods. In some area’s weeds were growing through pavers. Gardens and potted plants were overgrown and had weeds. In some areas large fronds had fallen from palm trees. Tables and chairs in some outdoor areas were dirty and marked. Spider webs were evident in some areas.

The Assessment Team identified the fire extinguishers on the level 2 deck in Lourantos wing were due for service in October 2020. A fire blanket was missing from its case in the communal area on level 2 of Lourantos wing.

There is a staircase in the middle of the main lounge area of Lourantos leading between the ground and first floor. Staff said only those consumers who do not have mobility issues use the stairs and most consumers with mobility limitations know not to use the stairs. However, they said some consumers living with dementia may forget that they should not use the stairs and for this reason staff monitor the stair area. Email communication provided to the Assessment Team, and interview with property management, shows that the stairs were identified as a safety issue sometime before July 2021 and it was initially suggested that a gate be placed on the stairs.

None of the maintenance issues identified by the Assessment Team were recorded in the reactive maintenance system.

The Assessment Team discussed observations of the service environment with management. They said they had identified that improvements were required. They said some maintenance issues had been delayed because of COVID-19. Cleaning commenced for some outdoor areas after the Assessment Team discussed the observations with management.

The approved provider responded to the Assessment Team’s report and advised that the fire contractor had been turned away from the service during the lockdown of 5/3/2022 - 7/04/2022, however it is noted that this was due for testing in October 2020. The provider has advised that site inspections have now been completed with the cleaning contractor to address the cleaning issues raised. In relation to the stairwell, a detailed report has been provided to the service, the provider advises that a risk assessment should be conducted and decision on installation of a gate must be made by the Executive Team. The Director of Property recommends against installation of the gate due to the building code non-compliances it will trigger, however has not provided an alternate solution.

Accordingly, I find requirement 5(3)(b) the service environment: is safe, clean, well maintained and comfortable; and enables consumers to move freely, both indoors and outdoors is not-compliant.

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

The Assessment Team found the service has a process for the regular maintenance of equipment. However, many regular maintenance items have not been completed since 2021. Property management explained that the when the service has a COVID-19 outbreak all critical maintenance was cancelled. They said the maintenance items which were due during the cancelled period will not be rescheduled but will be picked up at the next scheduled check. This includes items which have 6 and 12 monthly service.

Maintenance staff said that in addition to a 6-monthly service by a contractor, lifters are checked each month and marked off on a sticker on the equipment. The Assessment Team sampled two lifters which were both last marked as checked in July 2021 and not since.

A SIRS report dated 26 January 2022 states that the service requires air mattresses to be installed within 24 hours of a pressure injury being identified. An air mattress was not installed for 3-4 days after pressure injury was identified.

A representative advised the Assessment Team of a large vinyl chair with large pieces of vinyl missing from the arms. The representative advised the Assessment Team it had been raised with various nursing staff, however nothing had happened. This is noted as potentially a risk for skin tears.

The approved provider responded to the Assessment Team’s report and advised that there had been miscommunication in relation to the critical maintenance work being cancelled. The provider is advised that work is only permitted where not completing work is a risk to staff or residents or may impact resident health and wellness. Assets that are critical and have statutory requirements - for e.g. fire, electrical, plumbing etc – have their maintenance. However, other items such as pest, air conditioning that are service monthly are generally not rescheduled unless a specific problem has arisen. This however does not address the issues raised where two lifters had not been serviced since July 2021, where they should be serviced monthly and the air pressure mattress not being installed immediately and the risk of skin tears from a chair, where this has been raised with nursing staff.

Accordingly, I find requirement 5(3)(c) furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer is not-compliant.

# Standard 6

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

## Findings

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

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

The Assessment Team interviewed consumers, representatives and found only one of the consumers sampled indicated that they were aware of the complaint processes in the service. Representatives also reported that they had not been made aware the process for raising complaints or external avenues for raising complaints. Some consumers indicated that they have been discouraged from making complaints because action was not taken when they had previously raised concerns.

The Assessment Team received feedback from consumers and their representatives saying that although they felt heard when they complain nothing changes and they are therefore discouraged from complaining.

A representative said they have never been told anything about the complaint system or how to raise a complaint externally. They have just been told to ring if they have a problem, but not what the process is or who to complain to. A representative said their family member living in the service always tells them there is no point in complaining; nothing ever happens so they just don't bother now.

One representative said that he was unaware of complaint forms or mechanisms he could use. He said he had complained to nurses but that is no use "it goes in one ear and out the other".

The Assessment Team interviewed staff, and when asked about what action they take when someone raises a complaint with them, 2 staff said they tell the person not to speak to them about it and to talk to someone in charge. When asked about how consumers are made aware of ways of raising complaints the general manager said they largely rely on Greek speaking staff and their communications with consumers to bring forward any complaints they might have.

There are several Commission ‘Do You Have a Concern’ posters in the service. There is also a suggestion box and some continuous improvement/ suggestion/concern forms at the unused reception desk outside the consumer areas of the service. There were no other brochures, posters or other information about complaint processes throughout the service. Management confirmed there was no other information about internal or external complaint avenues and processes in the service.

The approved provider responded to the Assessment Team’s report however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 6(3)(a) consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints is not-compliant.

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

The Assessment Team reviewed minutes of the resident meeting on 22 April 2022 which states that the meeting discussed what OPAN (Older Persons Advocacy Network) is and that the service could be contacted via a link that was going to be provided to their website. However, the only information about advocacy services available in the service were a few brochures for the outdated Senior Right Service; there were no brochures for the current OPAN service (Older Persons Advocacy Network). These brochures were only located near the reception desk which is currently not used and is away from consumers’ areas. The Senior Rights Service Brochures were only available in English.

The Assessment Team interviewed consumers and representatives who were unaware of any external services that could assist them if they had a concern.

The Assessment Team spoke with staff who advised that they have wanted to refer a consumer to the Older Person’s Advocacy Network and advised management of this; but it “just didn’t happen”. They said they had sent an email to the chief executive officer for advice about how to move forward with the consumer’s issues but have not received a reply.

The approved provider responded to the Assessment Team’s report and advised that on several occasions over the last 4 months, including in the meeting on 22 April, the OPAN and Seniors Rights Services information/flyers have been printed and disseminated to residents. Copies of these in English and in Greek have been provided. They have been shared with consumers in print as well as in written form in English and in Greek in communications directly to residents during the COVID outbreaks. Representatives were also provided with the OPAN and Seniors Rights Service contact details in written updates as well as in regular online meeting presentations.

I have considered the approved provider’s response and have found that the provider is compliant with this requirement 6(3)(b).

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

The Assessment Team interviewed consumers and representatives who reported that action is not taken when they raise concerns about care and services, or that action taken is not effective in resolving their complaints. One consumer said it is no good complaining about anything to the nurses because nothing happens. A representative said they have complained on multiple occasions about aspects of care and services, but nothing happens. They said this seems to be what happens all the time. They said they understand everyone at the service is "under the pump but this is unacceptable”.

The service provided the Assessment Team with a folder of compliments and complaints. Although multiple consumers complained about aspects of care and services which they indicated had not been addressed satisfactorily, there are no records in the complaint folder regarding most of those issues and there is therefore no documentation to indicate that the complaints were investigated, and action taken to resolve the issue.

For the complaints which were included in the folder there is documentation regarding some investigation of issues raised in the complaint and remedial actions to be taken. However, the remedial actions tend not to be specific and do not include any evaluation to ensure the actions were implemented or have been effective.

Throughout the site audit management consistently used the statement that they were following open disclosure when they referred to issues they had identified in relation to care and services. However, the Assessment Team identified that the staff do not have knowledge about the concept of open disclosure and do not always practice open disclosure, despite the team being provided a training folder stating that all staff had completed mandatory training, including open disclosure, only 1 of 4 staff asked about open disclosure was aware of the concept.

The approved provider responded to the Assessment Team’s report and furnished a copy of training records; however, this did not demonstrate that the staff were competent in this in practice.

Accordingly, I find requirement 6(3)(c) appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong is not-compliant.

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

The Assessment Team asked management to provide information to demonstrate trending and analysis of complaints; no information was provided regarding this.

The Assessment Team identified that the service is not ensuring that complaints are captured and processed through the complaint system and this does not enable the extent and type of complaints to be determined. Many of the reported complaints were not evident in the complaint register. The plan for continuous improvement does not indicate any improvements made as a result of consumer feedback.

The Assessment Team found that extensive deficiencies identified throughout the site audit indicate that concerns about care and services do not result in improvements. For example, the complaint folder included an investigation about a complaint received from representative about the end of life care of her consumer. The actual complaint and satisfaction of the complainant are not included in the folder; the complaint report only states that the representative was unsatisfied with the palliative care provided to her consumer. The report is undated, but it appears that the complaint related to care provided in early 2022. The Assessment Team have identified ongoing issues in relation to end of life care. There are no activities on the plan for continuous improvement about the issues identified in the complaint.

The approved provider responded to the Assessment Team’s report however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 6(3)(d) feedback and complaints are reviewed and used to improve the quality of care and services is not-compliant.

# Standard 7

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| Human resources | | Non-compliant |
| 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. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Non-compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

## Findings

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

**The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.**

The Assessment Team found that the organisation does not have sufficient staff numbers, with appropriate skills and qualifications to provide safe and quality services to consumers.

The Assessment Team interviewed consumers and representatives who said that there are not enough staff at the service or that if there were enough staff, they were not well trained and did not know the consumer. Consumers and representatives said that that consumers were not getting enough one to one time with them as staff were too busy.

The Assessment Team interviewed staff who said that vacant shifts are often filled with agency staff when available, however agency staff often need more supervision if they were unfamiliar with the area or with consumers. One clinical care staff said they had to write up notes at night as there was no time during the shift. One care staff said if staff turned up there was generally enough time to do their work, but they could spend more one on one time with consumers if there were more staff.

The general manager stated that the organisation has put in place a plan of action to improve the quality of service over the past four months including: restructuring of the service’s management team, a review of rosters and a reduction in agency staff. The management team said the plan of action was in progress and would take some time to see results. The general manager said it was challenging to find permanent staff.

The Assessment Team found that the service does not have an effective system in place to monitor call bell response times. Several consumers said they often had to wait a long time for staff to respond to their call bells and that this was an ongoing problem. The general manager advised the organisation’s policy was for staff to respond to call bells promptly and within 10 minutes. However, the service does not routinely review call bell response times including those greater than 10 minutes.

The approved provider responded to the Assessment Team’s report and advised that recruiting for all vacancies to ensure we can reduce agency staffing, the provider advised they have recruited 20 new staff since February and are undergoing compliance checks for other positions at the service.

I acknowledge the initiatives that the provider has put in place to reduce agency numbers and have a more consistent permanent staff base, and it will take some time to reflect the benefits, however at the time of assessment, I find that the provider is not-compliant with this requirement 7(3)(a).

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

The Assessment Team found that not all interactions with consumers are kind, caring and respectful. Several consumers and representatives have complained regarding the quality of staff and staff not understanding the consumer’s needs.

The Assessment Team interviewed consumers and representatives who advised that due to the numbers of agency staff, they are not familiar with consumers’ needs and do not know what to do and do not understand their identity, agency staff do not have access to care records. Representatives said agency staff are not supervised, they often see them watching TV, on their phones or sitting talking to each other when consumers are calling out for help.

The Assessment Team observed several occasions where staff were sitting in activities rooms not actively engaging with consumers or watching TV, sitting in smaller sitting areas on their phone and staff in nurses’ stations when consumers were calling out and not responding.

One representative said some staff go above and beyond their roles in caring for consumers however not all staff do this. One consumer said that some staff are good some are not. She said that night staff are often rude to her.

The approved provider responded to the Assessment Team’s report, however did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 7(3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity is not-compliant.

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

The Assessment Team found that staff do not always have the skill and knowledge to effectively perform their roles. Agency staff commencing at the service have little or no orientation into their roles. Several consumers and representatives have complained or commented on the lack of knowledge regarding agency staff at the service.

The Assessment Team interviewed consumers and representatives who provided feedback, with one consumer saying that the agency staff didn’t know how to put compression stockings on the consumer as she hadn’t seen it done before. A representative said their family member living at the service doesn’t trust the agency staff because they don’t know what they are doing. As a result, she won’t take any medication from them and insists on double checking with a regular nurse before she will take them.

The Assessment Team interviewed staff, with one agency staff member saying that they did not have any orientation or education by the service before commencing duties at the service but had experience from previous work. Another agency staff said they had received all training including induction at their agency. When asked how they knew consumer care needs they said there was a “mobility plan” on the cupboard in consumer’s room or she would ask other staff.

One staff member advised the team, that she did not have the qualifications to perform her role but would be commencing education this year. The Infection Prevention Control Leads did not have the relevant qualifications, however have since completed the course.

In discussion, the management team advised that the organisation has a preferred agency staff list to call on when agency staff are required. They said they will rely on the agency staff training provided by the preferred agencies. However, they were not sure if training provided by agencies to their staff was adequate in meeting the specific requirements of the Quality Standards.

The approved provider responded to the Assessment Team’s report however, did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 7(3)(c) the workforce and the members of the workforce have the qualifications and knowledge to effectively perform their roles is not-compliant.

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

The Assessment Team found that staff at the service are not trained to effectively support consumers at the service in their personal and clinical care. Consumers and representatives did not feel that all staff are well trained in their roles.

The Assessment Team interviewed staff and found that several staff said they had completed mandatory training as required however were unable to describe terms and processes required for their roles such as: SIRS (Serious Incident Response Scheme) training, elder abuse, dignity of risk and open disclosure. Care staff and clinical staff were not familiar with the term antimicrobial stewardship. Agency staff are not always provided the necessary training either through their agency or by the service to perform their roles. They do not have access to electronic consumer records and often rely on other staff to advise them on processes.

The Assessment Team found that there had been no education for catering staff about IDDSI (International Dysphagia Diet Standardisation Initiative) and preparation of texture modified meals for a long time, possibly several years.

Management advised the team that the organisation has implemented a new training schedule over the past two months. They said that 100% of staff have completed mandatory and competency training according to exception reports for staff undertaking training.

Whilst the organisation has contributed additional training resources for staff to complete mandatory training and competencies, extensive deficiencies across all 8 Standards demonstrate that staff training, and support has not been effectively to deliver the outcomes required by these Standards.

The approved provider responded to the Assessment Teams report with a list of competencies completed by staff before and after the site audit, however it did not demonstrate that the training was effective for staff to utilise this training in practice.

Accordingly, I find requirement 7(3)(d) the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards is not-compliant

**Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.**

The Assessment Team found that the service does not have an effective system and process to monitor and review the performance of each member of the workforce. Records reviewed did not indicate that staff requiring performance management have been identified or processes followed to effectively manage performance. SIRS reporting documents state that actions to mitigate incidents include “warning and education to be provided” however there was no indication that actions have been completed or outcome evaluated.

The general manager provided two training records for staff involved in incidents of neglect and inadequate manual handling, but training provided was only general and did not include these areas.

There was no documentation or staff files provided to indicate that investigation had occurred into an incident. Documentation did not indicate that staff were communicated with in a proper manner with actions agreed to and an ongoing plan or monitoring of performance.

The approved provider responded to the Assessment Team’s report and provided the two staff members learning requirements based on their performance management, however it did not show the communication, plan for improvement or monitoring of performance and outcome.

Accordingly, I find requirement 7(3)(e) regular assessment, monitoring and review of the performance of each member of the workforce is undertaken is not-compliant.

# Standard 8

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

## Findings

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

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

The Assessment Team found that consumers are not supported to be engaged in the development, delivery and evaluation of care and services and to partner in their care.

The Assessment Team found that the service was unable to provide information regarding consumers or representatives involvement in service level representation to the Board in decision making for example in staff recruitment or service design.

The service’s plan for continuous improvement includes an action item for consumers to participate in planning their services. This does not appear to have occurred.

The service does not participate in a Partners in Care program. The management team advised that this program was not introduced at the service as they did not have enough time to arrange this. Two representatives said they could not come in to see their family member at the service during COVID-19 even though they were providing daily supports for them such daily meal assistance or emotional support. One representative was denied access to her consumer before passing.

One relative meeting has been held since the outbreaks at the service. Relative meeting minutes do not indicate that consumers or representatives were invited to provide feedback at the meeting. One representative said she has never been invited to a relative meeting. The service has not undertaken a consumer satisfaction survey for over 12 months.

The approved provider responded to the Assessment Team’s report and advised that although there has only been one resident meeting, several pieces of communication have been provided to representatives which include the offer to connect and provide feedback, however this does not persuade me that the provider is compliant with this requirement.

Accordingly, I find requirement 8(3)(a) consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement is not-compliant.

**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 identified deficiencies across all the Quality Standards which indicate that the organisation’s governing body does not currently promote a culture of safe, inclusive and quality care and services and are not accountable for their delivery.

The Assessment Team spoke with the chief executive officer who advised that the Board is trying to change the culture of the service and since late 2021 the organisation has engaged several external consultants to assist in updating the service’s systems and processes including the development of policies and procedures to meet the Quality Standards. He said that it has been challenging for the service to provide detailed clinical reports as the management, clinical governance and quality teams have only recently been engaged. The chief executive officer that that the two COVID-19 outbreaks at the service have impacted on the service.

The chief executive officer advised that over the past two months the Board has commenced receiving revised monthly reports including from the clinical governance committee, director of quality risk and compliance and the general manager which includes overall issues with regard to the quality of care at the service. More detailed information is managed at the clinical governance committee and quality and compliance team levels.

The approved provider responded to the Assessment Team’s report and advised that Each month, the full board receives and notes the minutes of the Quality Improvement and Governance Committee board sub-committee, which meets monthly. The sub-committee receives and considers detailed facility reports each month, as well as reports relating to facility maintenance, hotel services and education.

I acknowledge the recent changed to reporting to the Board, however it will take some time until these improvements are reflected and demonstrate the culture of safe, inclusive and quality care and services.

Accordingly, I find 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 is not-compliant.

**Effective organisation wide governance systems relating to the following:**

1. **information management;**
2. **continuous improvement;**
3. **financial governance;**
4. **workforce governance, including the assignment of clear responsibilities and accountabilities;**
5. **regulatory compliance;**
6. **feedback and complaints.**

The Assessment Team found that the organisation’s governance systems in place are ineffective regarding information management, continuous improvement, workforce, regulatory compliance and feedback.

The Assessment Team found that the systems for information management do not provide sufficient, consistent or readily available information for staff and management to perform their roles effectively. This was identified where clinical documentation is inconsistent, monitoring charts are not routinely completed, or timely referrals are not made to meet consumer needs.

The service does not have effective continuous improvement systems in place. The service’s systems to collect and review the feedback of consumers and their experience is not included as part of the quality improvement system. The continuous improvement plan has not been evaluated for the effectiveness of actions taken despite being recorded as closed.

The organisation has not taken effective steps to mitigate significant incidents at the service and deficiencies in the effectiveness of interventions is not always evaluated and documented. Serious Incident Response Scheme (SIRS) documentation does not indicate that incidents have been fully investigated, strategies implemented, or evaluations undertaken for their effectiveness. Several incidents recommend education and training; however, no evidence has been if this has occurred. Training and education about SIRS have not been effective in ensuring incidents are managed in the organisation’s incident management.

The site identified deficiencies in relation to feedback and complaints, where open disclosure is not utilised, feedback and complaints do not inform continuous improvement and complaints and feedback is not managed appropriately.

The approved provider responded to the Assessment Team’s report and advised that mandatory training and policies and procedures would be rolled out to staff during May and June 2022.

Accordingly, I find requirement 8(3)(c) effective organisation wide governance systems relating to; information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance and feedback and complaints is not-compliant.

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

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

The Assessment Team found that the organisation does not have an effective risk management system and practices are not in place at the service relating to managing risks to the health, safety and well-being of consumers. Identified risks are not being effectively evaluated to reduce or remove the risks in a frame that matches the level of risk and how it is affecting consumers

The management team confirmed that the service still has several high-risk consumers due to inadequate staffing and ongoing historical issues. They advise the general manager now has two full time care managers who are focused on mitigating the high risk, however agency staff numbers remain high and are attributing to ongoing risks. The said their human resources department is providing targeted support to recruit care staff and registered nurses.

The service has a risk management framework which was completed over the last two months however flowcharts for registered and enrolled nurses to guide them has not yet been implemented. Education records indicate that training has not been provided to staff regarding managing high risk.

The approved provider responded to the Assessment Team’s report and provided a screen shot of the high impact and high prevalence risks, which develops a score based on risks, however this alone does not address the deficiencies identified with regard to this requirement including the management of pain, wounds and restrictive practices, the lack of clinical oversight within a range of specialist care needs and the services response to managing deteriorating consumers. There is a lack of effective strategies to manage these risks identified.

Accordingly, I find requirement 8(3)(d) effective risk management systems and practices, including but not limited to; managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system is not-compliant.

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

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

The Assessment Team found that the organisation has a clinical governance framework that was implemented in 2021 and which includes antimicrobial stewardship, minimising the use of restraint, and open disclosure. The organisation has clinical policies and procedures to guide management and staff to deliver safe and quality clinical care. However, a review of documentation, feedback from staff and observations of staff practices show a lack of standard and transmission-based precautions are in place to prevent and control infections.

The Assessment Team identified deficiencies in relation to all Standard 2 and 3 Requirements which demonstrate that the clinical governance framework has not been effective in ensuring clinical care which is safe, effective or high quality.

The Assessment Team interviewed staff and found that although some staff have a good understanding of antimicrobial stewardship, many did not, and this included registered nurses. Feedback was that they could not remember having any training on the subject. Most staff did not have a reasonable knowledge of open disclosure.

The Assessment Team identified that open disclosure has not always been practiced. Although management reported that SIRS incidents were thoroughly investigated, the outcomes of investigations have not been reported to consumers or representatives.

The approved provider responded to the Assessment Team’s report however, did not produce evidence to support their compliance in this requirement.

Accordingly, I find requirement 8(3)(e) where clinical care is provided—a clinical governance framework, including but not limited to the following: antimicrobial stewardship; minimising the use of restraint; open disclosure is not-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-2)