St George Aged Care Centre

Performance Report

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BEXLEY NSW 2207  
Phone number: 02 8566 1400

**Commission ID:** 2558

**Provider name:** Marlowe Homes Pty Ltd

**Site Audit date:** 1 March 2022 to 15 March 2022

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

# Performance report prepared by

Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment conducted on 1 March to 4 March 2022, observations at the service, review of documents and interviews with staff, consumers/representatives and others. Further documentation was provided by the approved provider to inform remote work from 7 to 15 March 2022.
* the provider’s response to the Site Audit report received 8 April 2022.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

To understand the consumer experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care and services records (for alignment with the feedback from the consumer), and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

The Assessment Team found that overall, consumers and representatives interviewed provided feedback about consumers being treated with dignity and respect with their culture respected and identity maintained.

The Assessment Team interviewed consumers and representatives who shared information that they believe staff respect and support the consumer culture and values. Most consumers and representatives thought consumers were supported to make choices about their day to day care and services and to maintain connections with others. Consumers and representatives provided positive feedback about information provision, including to exercise choice. Consumers and representatives provided positive feedback about consumer privacy being maintained.

The Assessment Team interviewed staff who spoke of and to consumers in ways that are dignified and respectful and which value consumer identity; and observations of staff interactions with consumers were mostly aligned. Related policy/procedure includes some guide for management and staff, but overall lacks detail and an organisational diversity action plan is in development.

The Assessment Team observed consumer life stories and assessments include some information about their culture. Related care plans showing culturally safe care and service planning and provision were not provided, however for some consumers there is some information in evaluation records indicating this has occurred. Management demonstrated an understanding of cultural safety. Staff demonstrated an understanding of consumer cultural and religious diversity. Cultural and spiritual events of significance to consumers have been promoted and celebrated, and cultural meal options and dining experiences provided. Improvements have been made relating to cultural safety for the consumers.

The Assessment Team identified that consumer supported decision making is understood and being supported. Consumer decision making preferences have been identified and documented. The representatives of consumers subject to restrictive practice do not have authority to authorise its use. This has been identified with actions underway to address this. An improvement has been made in relation to consumer decision-making.

The Assessment Team interviewed management who explained the system and processes for supporting consumers to take risks to live their best life. They advised consumers who choose to smoke or use bedrails have been supported; as has a consumer who goes out of the service. However, the records reviewed, and observations made do not demonstrate for most consumers sampled that safety considerations have been effectively balanced with dignity of risk to support those consumers to live their best life.

Management and staff described a range of ways they communicate with consumers and representatives. Review of documentation confirms this. An improvement has been made in relation to information provision.

The organisation has a personal privacy policy and staff described ways they maintain consumer personal privacy, however some observations made by the Assessment Team show this does not consistently occur. The organisation’s information privacy does not set out how compliance with all relevant matters is maintained. The organisation has posted consumer photographs on a social media platform and it has not been demonstrated that consent has been obtained for this.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

### Requirement 1(3)(d) Non-compliant

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

The Assessment Team interviewed management who explained the system and processes for supporting consumers to take risks to live their best life. They advised consumers who choose to smoke or use bedrails have been supported; as are consumers who leave the service. However, the records reviewed, and observations made do not demonstrate for most consumers sampled that safety considerations have been effectively balanced with dignity of risk to support those consumers to live their best life.

The Assessment Team reviewed the electronic care planning system and found that for consumers who chose to smoke cigarettes, there was no smoking or related risks identified or dexterity issues for consumers or strategies to reduce the risk of self-injury if the consumer chooses not to wear a smoke retardant apron.

The Assessment Team identified for consumers with bedrails, that assessments lack information about risks involved with using bedrails and the monitoring of consumers when using bedrails was not apparent.

The approved provider responded comprehensively to the Assessment Team report and included their action and training plan. The service has committed to ensuring staff are aware of consumer risk and will undertake assessments and care planning reviews for every consumer ensuring their individual needs, preferences, and goals are clearly identified for staff to provide effective care, including smoking and risk assessments. The service has also committed to an extensive staff training schedule to commence in early May 2022.

I acknowledge the comprehensive response and actions that the service has initiated, however, recognise that these actions will take some time to reflect compliance. I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

### Requirement 1(3)(f) Non-compliant

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

The Assessment Team found that consumers and representatives provided positive feedback about consumer privacy being maintained. The organisation has a personal privacy policy and staff described ways they maintain consumer personal privacy, however some observations made by the Assessment Team show this does not consistently occur. The organisation’s information privacy policy does not set out how compliance with all relevant matters is maintained. The organisation has posted consumer photographs on a social media platform and it has not been demonstrated that consent has been obtained for this.

The Assessment Team observed consumers using the bathroom without the bathroom door closed. A lifter sling was being stored in a consumer’s room and staff would go in and out of the consumer’s room to access the sling.

The Assessment Team asked the manager how consent is gained for use and disclosure of consumer personal information (photographs) posted on a social media platform (Facebook) for the service. The facility manager advised there is a privacy consent form for photographs. The privacy consent form provided includes that personal information collected may be disclosed to others who require it to provide care and services and that photographs will be published in newsletters, used for clinical purposes and in the emergency evacuation records. There is no information giving consumers a reasonable expectation their photographs will be used for other communications or marketing and will be disclosed on social media. Consent for this specific use on social media and disclosure of consumer personal information is not being obtained.

The approved provider responded to the Assessment Team’s report and advised that the social media page has been taken down and the correct consent has been obtained. A review is scheduled for the Privacy Policy and the Social Media policy and Resident Handbook. Education will be provided to all staff on dignity, privacy, and consumer safety.

I acknowledge the work that the provider has committed to, however recognise it will take some time before results are reflected. I find that the approved provider is not compliant with this requirement.

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

To understand the consumer experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care and service records in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

The Assessment Team found that some sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. Most representatives said the service communicated with them about changes to the consumer’s care and services.

The Assessment Team interviewed consumers and representatives and found that some representatives did not know about care plans and some have not been given the opportunity to have input into care planning. One representative said they had seen a care plan about a year ago.

The Assessment Team identified that assessment and planning do not always consider risks to the consumers' health and well-being and do not always inform the delivery of safe and effective care and services. While the service has a schedule to guide staff in completing assessments on entry to assist in the development of care plans, the process is not always followed. Review of care and service records shows for some consumers assessments are not completed and for some consumers risk assessments are completed, but the information is not used to manage risk.

The Assessment Team reviewed assessments and care plans and found that they lacked information to identify and address consumers' current needs and preferences. Advanced care directives have been completed for some consumers.

Care planning documentation for the consumers sampled does not generally reflect the consumer is a partner in their care. Management said case conferences to discuss care plans have commenced, but these are in the early stage of implementation.

The Assessment Team found that whilst there are some systems for communicating the outcomes of assessment and care planning to consumers or their representatives, overall these are not being implemented.

While there is some evidence of a consumer of the day process and review of consumers' condition, this process and other processes do not show staff are effectively evaluating the care and services when circumstances change or incidents impact on the needs, goals and preferences of the consumer.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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 found that assessment and planning does not always consider risks to the consumers' health and well-being and does not always inform the delivery of safe and effective care and services. While the service has a schedule to guide staff in completing assessments on entry to assist in the development of care plans, the process is not always followed. Review of care and service records shows for some consumers assessments are not completed and for some consumers risk assessments are completed, but the information is not used to manage risk.

The Assessment Team reviewed care planning documentation and found that although in some cases several assessments had been completed, these included incorrect information, they lacked detailed information in relation to behaviour, dietary requirements, cognition, depression, emotional well-being, lifestyle, sleep and rest and did not inform the delivery of safe and effective care and services and did not consider risks to consumers’ health or strategies to manage those risks.

The approved provider responded to the Assessment Team report and provided an action and training plan and have committed to a number of actions including reviewing 100% of consumers’ assessments and care plans to ensure that all required assessments have been fully completed and in consultation with the consumer and representative and ensuring risk assessments are undertaken for all consumers with identified risks.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 2(3)(b) Non-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 found that assessments and care plans were found to lack information to identify and address consumers' current needs and preferences. Advanced care directives have been completed for some consumers.

The Assessment Team reviewed care plans and noted for a consumer experiencing unplanned weight loss, there were no management strategies in place to assist the consumer to eat. The Assessment Team also observed for other consumers their care plans had not been updated to reflect their current needs for clinical care, personal care or activities for daily living. It was also identified that lifestyle plans did not contain current needs, goals or preferences.

The approved provider responded to the Assessment Team report and provided an action and training plan and have committed to a number of actions including reviewing all assessments and care plans for consumers, ensuring they are up to date, person centred and personalised, and that there is evidence that consumers/representatives have input in the planning of care. Training will include educating all staff who have responsibility to undertake assessment, that care planning is documented, current, person centred and personalised.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 2(3)(c) Non-compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

The Assessment Team found that care planning documentation for the consumers sampled does not generally reflect the consumer is a partner in their care. Consumers and representatives interviewed were not aware of opportunities to be involved in consumer care planning. Management said case conferences to discuss care plans have commenced however are in the early stage of implementation.

The Assessment Team identified that some assessments and care plans include preferences and goals, but without any evidence these have been identified and developed in discussion with the consumer or representative; and the sign off section to demonstrate this has occurred is left blank.

The Assessment Team interviewed sampled consumers and representatives, with one representative saying that they had seen a care plan about a year ago and the others saying that they had never seen a care plan and have never been invited to have any input into the development of a care plan.

The approved provider responded to the Assessment Team report and provided an action and training plan and have committed to a number of actions including ensuring all consumers and representatives are consulted regarding preferences and choices and accurately documented preferences and choices. Ensuring that all care staff are aware of the needs, goals, preferences and choices for each consumer and that consumers/representatives have opportunities to be involved in planning care. Undertake case conferences with all consumers and/or representatives as a matter of urgency. Provide consumer and/or representative a copy of the care plan and make any changes based on feedback and consultation.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 2(3)(d) Non-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 sampled consumers and representatives who provided feedback that did not demonstrate they had been consistently informed of the outcomes of consumer assessment and care planning. While there are some systems for communicating the outcomes of assessment and care planning to consumers or their representatives, overall these are not being implemented.

The Assessment Team reviewed consumer care and service records which did not show that the outcomes of assessment and care planning are being communicated to consumers or their representatives. Case conferences are yet to occur for most consumers. The consumer of the day process was not evident for most consumers sampled, and for two consumers sampled where this had occurred it was not evident there had been any communication with the consumer or their representative. Progress notes reflect some communication with consumer representatives when there is a change in the consumer’s condition or an incident occurs, however this did not show information was shared about the outcomes of related assessment and planning.

The approved provider responded to the Assessment Team report and provided an action and training plan and have committed to a number of actions including provision of education to the RN's on incident management, the deteriorating consumer and how to communicate and document consumer changes in a timely manner. Monitoring by the Facility Manager/Care manager to ensure timely information is provided and policy is adhered to and seeking feedback from consumers/representatives to ensure that they are satisfied and have understood all information provided.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 2(3)(e) Non-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 found that while there is some evidence of a consumer of the day process and review of the condition of consumers, this process and other processes do not show staff are effectively evaluating the care and services when circumstances change or incidents impact on the needs, goals and preferences of the consumer.

The Assessment Team reviewed care planning documentation and noted that when incidents had occurred, assessment and care planning had not been updated and incidents were not investigated, or preventative strategies put in place or evaluated for effectiveness. The Assessment Team raised this concern with management and were advised that in relation to incident management and prevention more broadly, the human resources challenges experienced at the service during the recent COVID-19 outbreaks had impacted on this occurring.

The approved provider responded to the Assessment Team report and provided an action and training plan and have committed to a number of actions including training staff in effective evaluation of care and services when circumstances change or incidents impact on the needs, goals and preferences of the consumer.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

To understand the consumer experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

The Assessment Team interviewed consumers and representatives who mostly considered that they receive personal care and clinical care that is safe and right for them. Most consumers and representatives interviewed said they were satisfied with how staff responded when they were unwell and with the treatment they receive. Most representatives interviewed said the consumer has access to a doctor or other health professional when they need it.

The Assessment Team found that clinical oversight is currently ad hoc and provided by the RNs and the advisor and nurse advisor. Senior staff were found to be new to the service and senior clinical positions had been vacant and/or were not always back-filled in the months prior.

The Assessment Team identified that each consumer is not receiving personal and clinical care which is safe and effective, consistent with best practice, tailored to the individual's needs and which optimises their health and well-being. There are significant gaps in the monitoring and management of behaviour, pain, weight loss, skin integrity, nutrition, bowels and medication incidents for consumers.

High impact and high prevalence risks associated with the care of each consumer are not being identified, monitored and managed. There has been a lack of clinical oversight for effective risk management.

The Assessment Team conducted interviews and reviewed documentation which indicated that overall needs, goals and preferences of consumers nearing the end of life are recognised and addressed and their dignity is preserved.

Consumers who experience a change of condition do not always have their needs recognised and responded to in a timely manner.

While assessment and care planning were found to have significant gaps and not effectively communicate information about the condition, needs and preferences of consumers, staff communicate in other ways such as handovers, communication books, alerts and progress notes. The communication with others where responsibility for care is shared has been effective overall.

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

The Assessment Team also identified that minimisation of infection related risks has not been occurring for the safety of consumers, as this relates to COVID-19 safe measures and broader infection and prevention control measures. However, it was demonstrated for the consumers sampled that there has been appropriate antibiotic prescribing.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that each consumer is not receiving personal and clinical care which is safe and effective, consistent with best practice, tailored to the individual's needs and which optimises their health and well-being. There are significant gaps in the monitoring and management of behaviour, pain, weight loss, skin integrity, nutrition, bowels and medication incidents for consumers.

The Assessment Team reviewed documentation which indicated monitoring of consumers’ wounds is occurring however there have been six pressure injuries acquired at the service between 10 October 2021 and 28 February 2022. Another pressure injury was acquired in hospital and identified as stage one when detected, however it has deteriorated to stage two.

The Assessment Team identified that medical and other allied health recommendations had not been updated in care plans. It was also noted that when falls or skin injuries had occurred there was no incident investigation or preventative actions and either no incident report or the incident review remains open without management review.

The Assessment Team noted that chemical restraint has been minimised, however in relation to bedrails, there has been a lack of risk assessment and management for some consumers.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including reviewing all policies and procedures to ensure that they are consistent with best practice and educate staff on this information. Provision of education to all staff in the monitoring and management of behaviour, pain, weight loss, skin integrity, nutrition, bowels and medication incidents. Ensuring that clinical oversight is occurring and effective and to recommence clinical governance meetings and provide clinical oversight.

A comprehensive training plan has been developed to address all issues raised.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team found that high impact and high prevalence risks associated with the care of each consumer are not being identified, monitored and managed. There has been a lack of clinical oversight for effective risk management.

The Assessment Team found for consumers with behaviour concerns, risk to themselves and other had not been effectively managed. Progress notes and other care and service records provided do not show when behaviours occur that staff consider the underlying factors or unmet needs which could be contributing to these and rule them out. In some instances, incidents are recorded on behaviour charts, however there is no information about triggers for behaviour and/or interventions trialled and there is no corresponding incident report. The team also identified a consumer with unexplained skin injuries and there had been no follow up to understand how these occurred.

The Assessment Team observed two consumers hit each other in the doorway to the lounge area in Rosella on 1 March 2022. This was reported to staff who collected urinalysis from the consumers, however, did not report this as an incident. This was followed up the next day after reporting to management. The staff member that the assessor spoke to said they misunderstood the assessor.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including provision of education for all staff on high impact and high prevalence risks with the Care Manager ensuring that all these risks are identified, monitored and managed.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

### Requirement 3(3)(d) Non-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 that consumers who experience a change in their condition do not always have their needs recognised and responded to in a timely manner.

The Assessment Team reviewed care planning documentation and found for one consumer where they complained of pain, a full pain assessment including location and type of pain was not documented.

The Assessment Team notes that for a consumer with unplanned weight loss, deterioration has not been managed effectively with lack of timely assessment, lack of communication between care and catering staff, lack of care staff understanding of dietary needs and food not provided consistent with the consumer’s preferences. Other factors possibly contributing to the consumer’s unwillingness to eat were not identified in a timely manner.

The approved provider responded to the Assessment Team’s report and provided an action and training plan to address the issues raised in the Assessment Team’s report.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

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

### Requirement 3(3)(g) Non-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 identified that minimisation of infection related risks has not been occurring for the safety of consumers, in relation to COVID-19 safe measures and broader infection and prevention control measures. The service did demonstrate for the consumers sampled that there has been appropriate antibiotic prescribing.

There have been six COVID-19 outbreaks at the service between August 2021 and February 2022.

The Assessment Team reviewed documentation including the consumer representative COVID-19 survey results from November 2021. Feedback from a representative, when visiting after the outbreak, no one undertook health screening or asked for evidence of a PCR/RAT test or vaccination status and the representative was allowed to walk freely around the service.

The Assessment Team reviewed progress notes which showed consumers were not consistently isolating in their rooms when COVID 19 positive. Observations and other information gathered by the Assessment Team during this performance assessment show overall there is a lack of controls and oversight for prevention of COVID-19.

The Assessment Team found prior to entering the service environment on 1 March 2022 that the recommended time following rapid antigen testing being undertaken had not passed before being invited into the service. The Assessment Team was not asked to provide evidence of COVID-19 vaccination prior to entering the service.

The Assessment Team found that the service did not demonstrate an understanding of or failed to follow public health orders and the requirement for visits to take place in outdoor areas or in consumer rooms (not common areas of the service).

The Assessment Team also noted that shared equipment is not being cleaned between uses including the one pen at the sign in desk for those signing in to use and there were no wipes on the table with them.

The Assessment Team found that the service provided an antimicrobial stewardship policy statement/definition and procedures. These include staff education should be on a regular basis and attention be given to pain control, hydration and bowel management.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including ensuring thorough and effective screening of every person who enters the home. Reviewing the current practices and consider implementing a person to assist with screening. Ensuring all shared equipment is wiped down between consumers with 100% compliance. Facility Manager and Care manager to monitor and ensure this compliance.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

To understand the consumer experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service. Staff were asked about their understanding and application of the requirements, and the team also examined relevant documents.

The Assessment Team found that overall, feedback from consumers and representatives was positive about the services and supports for consumer daily living.

The Assessment Team interviewed consumers and representatives, representatives provided feedback about their relative being supported to maintain contact with family for emotional support and support for consumer spiritual well-being was positive. Positive feedback was received from the representative of a husband and wife who live at the service about staff supporting them as a couple. Most consumers and representatives gave feedback about consumers enjoying the meals and all explained meals are of sufficient quantity.

The Assessment Team did however receive some opposing feedback including that they would like consumers to be involved in more activities or to spend more time outside and provided information about a lack of support to do things of interest to them. A representative said they do not know if consumers have been emotionally supported at the service or with their mental health, noting it has been a difficult time for them during the recent COVID-19 outbreaks. Two representatives provided information about their relative not enjoying the meals. One other representative provided feedback about the meals not being varied for their relative who needs a specialised diet.

The Assessment Team found that the leisure and lifestyle service and support needs of some consumers sampled have been identified and documented, but this has not occurred for others. The consumers sampled have been involved in activities of interest to them but have had minimal participation, including a consumer who has been assessed as requiring these supports for behavioural management. The Assessment Team acknowledges adjustments had to be made to the programs due to the COVID-19 outbreaks. One to one supports were to be provided, however it was not demonstrated they have been provided often. During the performance assessment minimal participation in activities and a lack of meaningful engagement was observed for many consumers. The need for improvement in relation to leisure activities has been identified. Improvements are planned with actions in the early stages of implementation, yet to be completed.

The Assessment Team interviewed staff who spoke about providing consumers with emotional support and consumer care and service records reflect this. Review of care and service records does not however show when consumers experience ongoing distress or sadness that this has been identified and addressed. Depression assessment and care planning has not occurred, and consideration has not been given to the need for psychological supports. The COVID-19 aged care grief and trauma support services have not been promoted and consumers have not been supported to access them.

The Assessment Team identified that there are supports and services for consumers of faith, to practise their faith in the way they choose. There are plans to strengthen the services and supports for consumers of Orthodox faiths. For one consumer, staff showed an awareness of their faith-based needs and preferences and spoke about the ways they support them. However, related care planning is not in place and records show support was provided to the consumer once in approximately 4 months.

The COVID-19 pandemic and recent outbreaks at the service have reduced to a great extent opportunity for consumers to be able to participate in their community. Information was provided about how this occurred previously. The care plan for a consumer has minimal information about the relationship with their partner, noting the relationship is complex and their partner is involved in their care; and it does not have guidance for staff about how to support them as a couple.

The Assessment Team found that there are gaps and inconsistencies in information held by the care and catering teams about consumers’ dietary needs and preferences, which has had impact on some consumers. There are some systems and processes for staff across departments to communicate with their colleagues about consumers’ needs and preferences, however these are not always used effectively. For a consumer where responsibility for care is shared, it was not demonstrated there has been effective communication with the external service provider.

The Assessment Team enquired with staff about how referrals are made to access volunteer visitors and religious services and supports for consumers. There is organisational policy/procedure with some guidance about making referrals. The Assessment Team notes some of these services have not been accessible in recent times due to the COVID-19 pandemic and COVID-19 outbreaks at the service. None of the consumers or representatives raised any concerns about accessing these services.

The Assessment Team found that there is a varied menu offering choice and cultural food options. However, there is a lack of understanding of consumer dietary needs and preferences. It was not demonstrated that the specialised dietary needs of some consumers have been considered and are being met. Based on findings from previous audits and observations made by the Assessment Team, food safety is not being maintained. Overall, it has not been demonstrated that meals are of suitable quality for consumer enjoyment, nourishment and safety. Effective and sustainable systems have not been demonstrated.

The Assessment Team observed some consumer equipment is not clean and in good condition. There is a lack of storage for keeping the equipment protected from the elements. This was identified six months ago and has not been addressed, but steps are being taken to address this. New consumer equipment is being purchased and put into use. However, there is not an effective system for identifying the suitable size sling for each consumer who needs a sling lifter for safe transfers. Staff say they have access to the equipment they need to deliver services for consumer daily living.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) 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 found that leisure and lifestyle service and support needs of some consumers sampled have been identified and documented, but this has not occurred for others. The consumers sampled have been involved in activities of interest to them but have had minimal participation, including a consumer who has been assessed as requiring these supports for behavioural management.

The service had had a consultant review compliance with the Quality Standards from 30 August to 2 September 2021, which noted that activities finish at 4pm each day and there are no specialised activities for consumers in the secure wing.

The Assessment Team observed minimal leisure activities and minimal consumers involved in leisure activities. Some group activities took place and there was consumer entertainment one morning. The Assessment Team acknowledges there was heavy rain during the performance assessment, precluding the use of outdoor areas for activities. However, many consumers were sitting inside in common areas or lying in their bed with no stimulation or engagement.

The Assessment Team requested lifestyle team progress notes for a sample of consumers for further information about lifestyle participation, consistent with the lifestyle coordinator’s advice these are being documented weekly for each consumer. These were not provided.

The Assessment Team reviewed the service’s Plan for Continuous Improvement which includes an entry about a lack of consumer activities during COVID-19 lockdown, including consumers sitting around with nothing to do and limited self- directed activities. The due date for completion was 26 November 2021. This information does not include details about results/outcomes for consumers. The leisure and lifestyle assessments have not yet been completed in the electronic care planning system for most consumers.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including immediately identifying gaps in lifestyle activities of interest to be addressed in consultation with consumers and representatives. Provision of education to be provided for lifestyle staff to ensure they understand what is required and that they have the resources available.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 4(3)(b) Non-compliant

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

The Assessment Team interviewed representatives who provided feedback about consumers being supported to maintain contact with family for emotional support. However, some representatives were unaware if consumers were emotionally supported at the service with their mental health, noting it has been a difficult time for them during the recent COVID-19 outbreaks.

The Assessment Team reviewed care planning documentation and found they do not show that when consumers experience ongoing distress or sadness this has been identified and addressed. Depression assessment and care planning have not occurred, and consideration has not been given to the need for psychological supports. The COVID-19 aged care grief and trauma support services have not been promoted to consumers and they have not been supported to access them.

The Assessment Team interviewed a coordinator who was not aware of referral options for other emotional and psychological services and supports for the consumers and said she has not made any, noting the clinical team may have done so.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including staff training in behaviour management, in particular distress and sadness and the need to document effective strategies on the care plan. Training will also be provided to all staff to effectively recognise and manage consumers’ feelings of sadness.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

### Requirement 4(3)(d) Non-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 identified that there are gaps and inconsistencies in the information held by the care and catering teams about consumers’ dietary needs and preferences, which has had impact on some consumers. There are some systems and processes for staff across departments to communicate with their colleagues about consumers’ needs and preferences, however these are not always used effectively. For a consumer where responsibility for care is shared, it was not demonstrated there has been effective communication with the external service provider. Overall, it has not been demonstrated information about the condition, needs and preferences of some consumers is communicated effectively within the organisation or with others where responsibility for care is shared.

The Assessment Team identified that although information was mostly held for consumers in relation to their dietary requirement, this was not always followed. The Assessment Team observed information for a different consumer who previously resided in the room in one consumer’s dietary records, the food that had been provided to the consumer was not in keeping with their dietary requirements and recommendations.

The findings from an internal food safety audit conducted in September 2021 include the folders containing consumers’ dietary requirement forms need to be checked as some are overdue for review and some are deceased or have been discharged. This either has not been addressed or the improvement made has not been sustained.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including undertaking a review of all care plans and assessments with goals needs and preferences to be collaboratively sought from the consumer / representative before being added to the care plan. The care plan is to be discussed at the case conference and adjusted as required. The menu is to be reassessed to ensure the chef in consultation with the dietician and consumer feedback, provides all International Dysphagia Diet Standardisation Initiative (IDDSI) levels of food texture for all meals.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

### Requirement 4(3)(f) Non-compliant

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

The Assessment Team interviewed consumers and representatives who mostly provided feedback about consumers enjoying the meals. However, the representatives of two consumers provided information about their relative not enjoying the meals and one other representative provided feedback about the meals not being varied for their relative who needs a specialised diet. There is a lack of understanding of consumer dietary needs and preferences. It was not demonstrated that the specialised dietary needs of some consumers have been considered and are being met. Based on findings from previous audits and observations made by the Assessment Team, food safety is not being maintained. Overall, it has not been demonstrated that meals are of suitable quality for consumer enjoyment, nourishment and safety. Effective and sustainable systems for meeting this requirement on an ongoing basis have not been demonstrated.

The Assessment Team observed that general food safety is not being maintained in the main kitchen or in the serveries/kitchenettes, this included food that should have been disposed of and containers storing dry foods were dirty. Flies were observed in the kitchen, a staff member said that this happens when the door is open for trolleys to go in/out. The Assessment Team observed on 3 March 2022 the kitchen door left propped open by a trolley, when trolleys had been returned to the kitchen after the lunch meal service.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including consultation with consumers on food they enjoy for snacks and provision of two menu items for all lunches. Creation of a specific PCI for catering incorporating the assessment review, the internal audit and the food safety audit. Ensure all food items are labelled with contents and an expiry date. This is to be monitored closely by General Manager/Facilities Manager. The service has also heightened its cleaning regime to address the issues raised by the Assessment Team.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 4(3)(g) Non-compliant

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

The Assessment Team observed some consumer equipment for use by or with consumers is suitable, clean and in good condition. The Assessment team observed consumer equipment stored outside was getting wet in the rain. In one internal courtyard, there is a partial roof, but it did not cover all of the equipment and water was seeping through joins and over edges dripping down onto the equipment. The equipment and lifter slings were wet. Most of that equipment had a rusty metal frame and/or was dirty. This included lifting machines for transferring consumers, wheelchairs, and a weigh chair.

The Assessment Team also observed in that vicinity, cigarette ash on the ground underneath some of the equipment. Some overbed tables inside the service have a rusty metal frame. A wheelchair belonging to the service and in use had a missing left armchair pad and hair on the seat back.

The Assessment Team spoke with the staff who said that while the equipment is rusty it is functional. Staff explained the equipment is wet and dirty as it is stored outside and is subject to the elements and that the lifter slings are laundered twice weekly. The team were advised that monthly checks of the consumer equipment is undertaken. The Assessment Team requested verbally and in writing the record of this when last undertaken. These were not provided.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including the immediate installation of storage sheds to keep consumers and lifting equipment out of the weather and all furniture and equipment to be checked and damaged ones to be repaired/discarded or purchase additional equipment as required.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

To understand the consumer experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed staff. The team also examined relevant documents.

The Assessment Team found that overall, consumers and representatives interviewed did not have any concerns about the service environment or the furniture, fittings and equipment. Most thought these were well maintained, and the service environment was safe. Most thought the service environment, furniture and equipment were kept clean, however some representatives raised concerns about cleanliness.

The Assessment Team observed the service environment is welcoming in some areas but not in others; it is not easy to understand and does not optimise each consumer’s sense of belonging, independence, interaction and function. Recent internal audit findings are consistent with those observations and the organisation does not have procedure showing how dementia enabling design is to be facilitated. There is information showing impact of the lack of dementia enabling design on some consumers. Information from interview with the approved provider and service management representatives and the service’s PCI, does not demonstrate comprehensive improvement planning or significant progress.

The Assessment Team observed the service environment enables some consumers to move freely, but it is not safe, clean and well-maintained. Some safety, cleaning and maintenance issues have been identified, with work planned but unable to proceed due to the COVID-19 outbreaks. However, some issues have not been identified. In recent months few maintenance requests have been made, environmental inspections have not been undertaken and cleaning audits have not been entirely effective.

The Assessment Team found that there are wide ranging issues with the cleanliness and condition of some furniture, fittings and equipment. Monitoring and review of all furniture, fittings and equipment was not demonstrated. Corrective actions were being taken during the performance assessment. However, effective and sustainable systems have not been demonstrated.

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

## Assessment of Standard 5 Requirements

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

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

The Assessment Team’s observations of the service environment are some areas are welcoming for consumers, such as the lounge areas, the chapel and some outdoor areas. However, other areas are not welcoming and it is not evident that the service environment easy to understand and optimises each consumer’s sense of belonging, independence, interaction and function.

The Assessment Team observed that for consumers to move between Cockatoo/Rosella and the chapel, they have to walk through the internal courtyard on the ground floor. There is not a covered walkway sufficient to protect consumers from the elements, such as the heavy rain which occurred during the performance assessment. Some outdoor areas do not have any shade for consumers to have protection from the sun or otherwise from the elements for consumers who smoke cigarettes.

The Assessment Team observed that there are few consumer rooms with visual cues to assist with room recognition. They have a name plate with the picture of the bird representing the area they live in and the room number. Some consumer rooms also have the consumer’s name on the room door in small print and/or a cultural decal on the room door. No visual cues individual to the consumers were observed.

In summary, a familiar space has not been created in all relevant areas which allows consumers to see and be seen and which supports consumer movement and engagement in the service environment.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including the consideration of long-term strategic planning and engaging a consultant to review layout and design of the service environment, and how it may be enhanced to assist consumers with dementia. Review of signage or other visual strategies to assist those consumers to find the bathroom, the dining room, the outdoor areas and their own rooms. Consider individualising the doorway or near the doorway to the rooms of the consumers to enable those with dementia to recognise their own rooms. Consider installing a covered walkway between Cockatoo/Rosella and the chapel, some shade in the outdoor areas for consumers who choose to smoke, regular environmental checks to ensure paintings and photographs on the walls are level and an overhaul of the environment to make it more welcoming and user friendly to enhance the consumers’ quality of life and wellbeing. The Governing Body, management team and maintenance department will review comments and identify short and long term solutions in consultation with consumers and representatives.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

*The service environment:*

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

The Assessment Team interviewed consumers and representatives who mostly gave positive feedback about the service environment, however some representatives raised concerns about cleanliness.

The Assessment Team observed fire and emergency evacuation safety issues including records of testing the fire safety fittings and equipment showed this last occurred on 27 December 2021, when prior to this it was being undertaken on a monthly basis. Signage for a fire extinguisher near an exit door to a courtyard on the ground floor, but a fire extinguisher was not present. Egress through the designated emergency exit door was blocked with a planter box. Egress through a designated emergency exit door to the outside of the building was impeded.

The Assessment Team also observed the service environment not to be clean or well-maintained with the walls and tiles in many areas dirty with dried drips and/or spills on them. The door frames for many room doors, including consumer room doors, had extensive chipped paint or other damage to them. Flies and other flying insects were seen inside the service in many different areas, including common areas, consumer bathrooms and the main kitchen. Cobwebs were seen inside the service in a number of areas, for example, on the clock above the designated emergency exit in the Cockatoo lounge.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including conducting a review environmental auditing processes as they are not currently capturing all issues. Develop and undertake three audits of the service environment - a safety audit, a maintenance audit of buildings and equipment, and an audit of the cleaning effectiveness. Include those issues already identified through the internal audit, the Assessment Team’s report and issues identified on the walk around by staff members, which will ensure all issues will be identified. For all three audits, an action plan will be created and allocated to members of staff (or outside contractors) with a realistic completion date. Conduct an audit of all emergency evacuation plans to ensure that they identify the locations of fire-fighting equipment and all emergency doors to be checked to ensure they are not blocked.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team identified wide ranging issues with the cleanliness and condition of some furniture, fittings and equipment. Few maintenance requests have been made to enable these to be addressed. Monitoring and review of all furniture, fittings and equipment was not demonstrated. Corrective actions were being taken during the performance assessment. However, effective and sustainable systems for meeting this requirement on an ongoing basis have not been demonstrated.

The Assessment Team observed handwashing sinks were dirty in the basin and around the sink hole. The external surfaces of many waste bins were dirty. In the main laundry on top of the laundry washing and drying machines and, on the fittings, and pipes/cords behind the machines there is an extensive build-up of dust. Other fittings and items were dusty, and some arm chairs have cracked arm rests or seating has stains.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including immediate discussion with contract cleaners addressing all cleaning concerns. Management to hold a weekly meeting with the cleaning contractors to discuss satisfaction and compliance with cleaning services. Continue with efforts to increase storage capacity as a matter of urgency as a result the shed has been purchased to be built and used as soon as possible. Following the audit of all furniture, fittings and equipment, dispose of and replace all dining chairs which are no longer serviceable or safe or clean if possible. Consider disposing of all material covered dining chairs and replacing them with a chair that is more functional.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

To understand the consumer experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – asking them about how they raise complaints and the organisation’s response. The team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

The Assessment Team found that most sampled consumers, or their representative, considered that they are encouraged and supported to give feedback and make complaints. However, some consumer representatives provided information that appropriate action is not taken in response to feedback and complaints and some consumers interviewed felt that changes were not made as a result of feedback and complaints. One representative said that the consumer had complained several times, but the same issue is occurring.

Service management advised the Assessment Team that they have recognised the need and has recently commenced the process of improving its feedback and complaints management systems and processes. The improvement takes into account analysing, recording, identifying and tracking resolution actions, and evaluating the outcomes of complaints. A new quality audits and insights program was recently implemented, which will increase capacity to capture consumer feedback through benchmarking surveys and to include insights gained about improvement initiatives.

The Assessment Team identified consumers are informed about how to provide feedback and make complaints in a number of ways. The consumer handbook has a section about feedback and complaints, advocacy services that can assist consumers and representatives to make complaints and how to access translation and interpreter services. The service newsletter features information on how to make complaints as do brochures at reception that are translated into multiple languages.

The Assessment Team interviewed staff who were able to explain how they respond when consumers make complaints and how they assist consumers with cognitive and sensory difficulties with communicating and those who cannot speak English to provide feedback and complaints to the service, such as using communication boards and interpreter services.

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

## Assessment of Standard 6 Requirements

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

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

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

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

### Requirement 6(3)(c) Non-compliant

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

The Assessment Team found consumers and representatives who had made a complaint expressed dissatisfaction as their complaint/s had not been resolved. Complaint records indicate the majority of complaints are closed without an evaluation of the outcome for the consumer regarding their health, safety or well-being. It was not sufficiently demonstrated that appropriate action is taken in response to complaints or that an open disclosure process is used when things go wrong.

The Assessment Team interviewed representatives who provided feedback indicating appropriate action had not been taken in response to their complaint and open disclosure had not occurred when complaints were made.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including the provision of education for management and staff regarding complaint management and open disclosure. Ensuring staff report all verbal complaints and that these are logged in the feedback register with all complaint outcomes to be evaluated for effectiveness.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

To understand the consumer experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumer about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

The Assessment Team found that overall sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

The Assessment Team interviewed consumers and representatives who confirmed that staff are kind and caring. Overall consumers interviewed confirmed that staff know what they are doing. Most consumers interviewed confirmed they think there is adequate staff. However, some representatives said staff levels were not sufficient and, on the weekends, there are less staff and it impacts on consumers being taken outside.

It was not demonstrated that the service has a workforce that is sufficient, skilled and qualified to provide safe, respectful and quality care and services.

The Assessment Team found that the service communicated with consumer representatives via email on two occasions during the COVID-19 outbreaks in January 2022 that it was 'critically short staffed' and ‘we are working very short on some shifts and other staff fare (sic) then expected to step up and work longer and more frequently with less time off between shifts'.

Throughout the performance assessment service management referred to a lack of clinical and managerial staff available during the COVID-19 outbreaks at the service between August 2021 and February 2022. They spoke of this being a major factor for not achieving planned improvements for the delivery of safe and quality care and services to consumers.

The Assessment Team observed that some staff demonstrated they did not have the required knowledge to provide safe and effective care and services to consumers in areas that they had received training, such as behavioural management, incident management, and dysphasia dietary standards. This has impacted on safe and quality care and service delivery to consumers.

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

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

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

The Assessment Team found that the service was unable to sufficiently demonstrate that its 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. Management said that prior to the performance assessment, the service was not regularly analysing data such as call bell response times to measure whether its staff mix and allocation was sufficient to provide responsive delivery of safe and quality care and services to consumers when and where it is needed. Service management frequently referred to a lack of qualified clinical and managerial staff available during the COVID-19 outbreaks at the service between August 2021 and February 2022 as the context for not achieving planned improvements for the delivery of safe and quality care and services to consumers.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including regularly analysing all clinical data, including call bell responses to provide evidence that the workforce is sufficient and suitably skilled. Management will review staffing and ensure sufficient staff are available for all contingency situations such as COVID-19 isolation and personal leave. The home is actively recruiting to ensure sufficient numbers of staff are available and a casual pool is in place. This will continue to ensure consistency of staff numbers with relevant qualifications to provide quality and safe care.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

### Requirement 7(3)(c) Non-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 the service had not sufficiently demonstrated that the workforce is competent and the members of the workforce have the knowledge to effectively perform their roles. Records were provided confirming staff have the required qualifications to perform their jobs. However, some staff demonstrated that they did not have the required knowledge to provide safe and effective care and services to consumers, in areas ranging from use of correct slings for lifting consumers, to meeting privacy and confidentiality requirements, to knowing about the dysphasia dietary standards.

Some staff interviewed demonstrated they did not have sufficient knowledge to effectively perform their roles.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including conducting a training needs analysis on the basis of the Assessment Team’s report with delivery of extensive and thorough mandatory training in all areas identified within the report.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 7(3)(d) Non-compliant

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

The Assessment Team found the service did not sufficiently demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. It is clear that the organisation has recently made a significant investment in staff learning and development, through the purchase of an online learning management system that delivers mandatory e-learning programs and significantly improves capacity to track and report on training compliance. The suite of mandatory training programs has high completion rates overall. Staff have been trained on some topics essential for maintaining the health, safety and well-being of consumers. However, review of the care and services for the consumers sampled shows staff lack knowledge relevant to their role and responsibilities.

While some staff demonstrated an understanding of SIRS and incident management, other staff lacked understanding of their responsibilities in relation to incident management and preventions. The Assessment Team’s findings are of a lack of effective incident management and prevention, for the health, safety and well-being of consumers as well as for regulatory compliance.

The approved provider responded to the Assessment Team’s report and provided an action and training plan which will include development of a full training plan to incorporate all gaps identified by the Assessment Team with the Governing Body to support and resource the training plan. Staff attendance at training sessions will be monitored with Human Resources reviewing and managing non-compliance with training.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 7(3)(e) Non-compliant

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

The Assessment Team found that the service did not sufficiently demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The service has a performance appraisal system. The service’s PCI includes an action to review the performance appraisal tool because it is too generic and does not assess the specific requirements of the job. However, the action to revise the form is not recorded on the PCI as completed by the due date and no outcome is documented as having been achieved.

The Assessment Team reviewed six care staff performance review documents provided by the service that were dated 8-20 February 2022. The forms contained a generic list of performance criteria and did not contain appraisal criteria specific to the job role. Four out of five forms had nothing recorded in the section about agreed goals for improvement. Another review included broad goals for improvement that were not specific to the role and responsibilities of the care staff member.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including personalising performance appraisals for every staff member to make it a useful tool ensuring that everyday language is used as many staff use English as their second language. Conduct a review of the staff appraisal tool as a matter of urgency, so the new tool can be used for the upcoming performance appraisals.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards). The team also interviewed consumers and representatives.

The Assessment Team found that most consumers and representatives interviewed confirmed the service is well run. However, they were unable to provide examples of how they are involved in the development, delivery and evaluation of care and services.

The Assessment Team found that the service did not sufficiently demonstrate that the governance systems are effective enough to oversee and ensure consumer health, safety, well-being and quality of life. The governing body states it is committed to strengthening its governance of the organisation and involving consumers and their representatives in the design, delivery and improvement of care and services. It has made a significant investment in new clinical, incident, policy and education management systems to that end. However, these are in the early stages of implementation. The systems, policies and procedures it currently relies upon are not effective for safe and quality care and services to consumers.

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

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) 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 the service had not sufficiently demonstrated that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Most of the service’s consultative forums/committees for consumers ceased over the period from August 2021 to February 2022 as the service managed 6 COVID-19 outbreaks and visiting restrictions tightened. They have not recommenced since this time. There was no other evidence presented by the organisation showing that consumers are currently engaged in and help shape the organisation’s governance.

The Assessment Team asked management, how the service involves consumers in the design, delivery and evaluation of services (other than through surveys), the general manager and facility manager explained that a number of the meetings have not recommenced since COVID-19.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including recommencing all meetings and consultative practices including case conferencing and consumer/relative meetings. Implementing a food focus group to actively seek feedback and solutions to food concerns from consumers and representatives.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 8(3)(b) Non-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 found that the organisation’s governing body had not sufficiently demonstrated that they promote a culture of safe, inclusive and quality care and services and is accountable for their delivery. The clinical and organisational governance systems and processes were not implemented during the last 6 months when there were multiple COVID-19 outbreaks at the service. Prior to that time there is evidence that clinical governance meetings were held on a semi-regular basis. However, minutes from those meetings and the new combined organisational and clinical governance meeting both contain minimal recording, identification and exploration of risks to the delivery of safe, inclusive and quality care and services or strategies approved by the governing body to mitigate those risks. Moreover, there is clear evidence that trend data provided to the governing body, on which care and service decisions and directions are to be based, is not always accurate to enable governing body accountability.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including recommencing all meetings, including clinical governance meetings and the provision of accurate and current data to ensure effective governance decisions can be made and risks clearly identified. Ensuring minutes of meetings held are complete and report all information required e.g. trend data, high impact high prevalence risks and resolutions are reviewed. Ensuring information flows up and down as appropriate and is communicated to all stakeholders.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 8(3)(c) Non-compliant

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

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

The Assessment Team found that overall it was not sufficiently demonstrated that organisation wide governance systems are effective enough to oversee and ensure the health, safety, well-being and quality of life of consumers. Service management repeatedly stated they recognise there is a need for significant improvements to the current governance systems. This included improvements to be made in the areas of information management, continuous improvement, human resource management, regulatory compliance and feedback and complaints.

The governing body has shown a strong commitment to strengthening its governance systems by recently investing in new systems, policies and procedures. However, these are in the early stages of installation and implementation. The systems, policies and procedures currently relied upon are ineffective and do not lead to safe and quality care and services for consumers.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including providing education to the governance team and managers to ensure that they clearly understand their roles and responsibilities in relation to providing safe care and services to the consumers. Complete review of all policies and procedures to ensure compliance with legislation and best practice and standards guidelines.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 8(3)(d) Non-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 effective risk management systems and practices were not demonstrated, leaving consumers vulnerable to significant risks to their health, safety, well-being and quality of life. Not all high impact and high prevalence risks associated with consumer care are being identified, monitored and managed in the areas of behavioural management, skin integrity and pain management; and there is a lack of clinical oversight for effective risk management in these areas. The Assessment Team found that there is ineffective identification and response of incidents and SIRS incident reporting has not consistently occurred. Risk assessment is not consistently carried out and communicated to support consumers to live the best life they can. There is under-recording of incidents through the IMS, and reported incidents are not consistently actioned and reviewed in a timely and effective manner.

In relation to the risk management system overall, the system presented is a generic risk management system with a work health and safety focus. The controls outlined include safe work procedures and there is a focus on ‘risks to health and safety’. It does not specifically address how high impact and high prevalence risks associated with the care of consumers are managed. The policy handbook does not explain the roles and responsibilities of staff, management and the governing body for managing risks to consumer health safety and well-being. The system includes standard risk management processes such as risk assessment, consultation, risk recording, developing risk controls/ mitigation strategies, prioritising the risk using a risk matrix, and monitoring and recording he effectiveness of mitigation strategies.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including that all consumers are to be reassessed and reviewed to ensure their risks are clearly identified and managed effectively. The risk management system to be reviewed and personalised for this home with a high impact high prevalence risk focus. Reporting, education and monitoring to be strengthened to ensure an effective sustainable system is in place.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### Requirement 8(3)(e) Non-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 current clinical governance framework is not effective. The existing clinical policy contains a brief procedural statement about clinical governance. It does not explain how clinical risk is identified and managed, nor how high impact and high prevalence risks are identified, and risk mitigation strategies evaluated to protect the health, safety and well-being of consumers. The statement does not sufficiently explain the practical application of open disclosure, antimicrobial stewardship, and minimising the use of restrictive practices. It does not explain the recent legislative changes to restrictive practices. Nor does it define the roles, responsibilities and accountabilities for clinical governance within the new organisational structure. Management said the service will be implementing a new customised online policy framework in the future. The current clinical governance framework in use is not fit for purpose.

The approved provider responded to the Assessment Team’s report and provided an action and training plan and have committed to a number of actions including conduct review of the clinical governance policy to include describing the practical application of open disclosure, antimicrobial stewardship and minimising the use of restrictive practices. Include recent changes to restrictive practices. Staff training in issues such as medication, skin, pain and behavioural management, including the need to record corrective clinical actions, strategies or directions driven from the level of the governing body. Management to ensure that open disclosure is consistently implemented, including when complaints are made and when consumer incidents and injuries occur.

I acknowledge the extensive work that the provider has committed to, however recognise that the results of these actions will take some time to demonstrate compliance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# 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)(d) Non-compliant

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

The approved provider must demonstrate:

* Consumers are supported to take risks with safety considerations being effectively balanced with dignity of risk to support those consumers to live their best life.
* Risks are identified and discussed with consumers and representatives.
* Risks are documented in the electronic care planning system and reviewed on an ongoing basis.
* Risk assessments contain information about risks involved for example the use of restraint, using bedrails or monitoring of consumers when using bedrails.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 1(3)(f) Non-compliant

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

The approved provider must demonstrate:

* Consent forms for use of consumer photographs on a social media platform for marketing purposes is explained to consumer and representative and consent documented.
* Doors are closed when consumer is receiving personal care and privacy and dignity is maintained.
* Equipment for use for other consumers should not be stored in a consumer’s room.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 2(3)(a) 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 approved provider must demonstrate:

* Assessment and planning documentation are accurately completed as scheduled in a timely manner and risks for consumers are considered, assessed and evaluated on entry and as circumstances change.
* Assessment and care planning documentation is reviewed frequently and when circumstances change with evaluation of risks and strategies.
* Strategies to prevent risks are monitored and evaluated for effectiveness.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 2(3)(b) Non-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 approved provider must demonstrate:

* Assessment and care plans detail comprehensive information and identify and address consumers' current needs and preferences.
* Advanced care directives are completed for all consumers.
* Management strategies are in place for consumers for personal and clinical needs.
* Assessment and care plans are updated to reflect consumers’ current needs for clinical care, personal care or activities for daily living.
* Lifestyle plans contain current needs, goals or preferences.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 2(3)(c) Non-compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

The approved provider must demonstrate:

* Consumers and representatives are involved in care planning and case conferences and provided with a copy of the care plan.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 2(3)(d) Non-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 approved provider must demonstrate:

* Care planning is completed in consultation with the consumer and representative.
* Outcomes of assessment and care planning are communicated with consumers and representatives.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 2(3)(e) Non-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 approved provider must demonstrate:

* Care and services are evaluated and documented in care plans when circumstances change or incidents impact on the needs, goals and preferences of the consumer.
* Incidents are investigated, and preventative strategies initiated and evaluated for effectiveness.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

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

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

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

The approved provider must demonstrate:

* Consumers receive personal and clinical care which is safe and effective, consistent with best practice, tailored to the individual's needs and which optimises their health and well-being.
* Monitoring and management of incidents or behaviours of concern, pain, weight loss, skin integrity, nutrition, bowels and medication incidents is undertaken and investigated for consumers with preventative measures in place.
* Risk assessment and consultation must be in place for consumers.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

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

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

The approved provider must demonstrate:

* High impact and high prevalence risks associated with the care of each consumer are identified, monitored and managed.
* Risks to consumers and others with behaviour concerns are effectively managed.
* Progress notes and other care and service records record when behaviours occur that staff consider the underlying factors or unmet needs which could be contributing to these behaviours and rule them out.
* Triggers for behaviour and/or interventions trialled are documented and incident reports are completed.
* Unexplained skin injuries are followed up to understand how these occurred.
* All incidents are documented and investigated.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 3(3)(d) Non-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 approved provider must demonstrate:

* Consumers who experience a change in their condition have their needs recognised and responded to in a timely manner.
* Full pain assessment including location and type of pain is documented for consumers complaining or exhibiting signs of pain.
* Unplanned weight loss, and deterioration is effectively managed with assessment and strategies to intervene in a timely manner.
* Communication between care and catering staff, to understand consumers dietary requirements is effective.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 3(3)(g) Non-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 approved provider must demonstrate:

* Infection related risks are effectively managed for the safety of consumers.
* Health screening and documentary evidence of vaccination is sighted before entry into the service as required under NSW Health Guidelines.
* Restrictions including isolation and PPE should be in place for infection control during COVID 19 or other infection as required by NSW Health Guidelines or Public Health Unit.
* Shared equipment is cleaned between uses, trolleys should have disinfectant wipes for use between consumers and rooms.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 4(3)(a) 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 approved provider must demonstrate:

* All consumers have lifestyle service and support needs identified and documented.
* Activities of interest are tailored for consumers for greater engagement.
* Specialised activities are developed for consumers in the secure wing.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 4(3)(b) Non-compliant

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

The approved provider musty demonstrate:

* Care planning documentation including depression assessment reflects when consumers are experiencing ongoing distress or sadness with psychological supports considered.
* The COVID-19 aged care grief and trauma support services are promoted to consumers with support provided to access the service.
* Staff are aware of referral options for other emotional and psychological services and supports for the consumers.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 4(3)(d) Non-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 approved provider must demonstrate:

* That there is effective communication and information sharing between care and catering staff information in relation to consumers’ dietary needs and preferences.
* Information in relation to consumers’ dietary requirement is always followed.
* Consumers’ dietary requirement forms are reviewed for accuracy.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 4(3)(f) Non-compliant

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

The approved provider must demonstrate:

* Food focus groups or consumer feedback is developed to provide feedback about meals.
* Food safety requirements are observed and maintained, and reviews of food and kitchen cleanliness is conducted.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 4(3)(g) Non-compliant

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

The approved provider must demonstrate:

* Consumer equipment is suitable, clean and in good condition.
* Equipment used for lifting consumers is maintained and kept in a covered area to prevent damage.
* All equipment is cleaned between consumer use.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

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

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

The approved provider must demonstrate:

* The service environment both inside and out should be welcoming and functional for consumers.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

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

*The service environment:*

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

The approved provider must demonstrate:

* The service environment enables consumers to move freely, is safe, clean and well-maintained.
* Fire safety fittings and equipment are maintained as required and in place at designated locations.
* Emergency exits are free of obstructions.
* Egress through the designated emergency exit doors allow consumers to move through in a safe manner.
* The service environment is clean and free of insects.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

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

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

The approved provider must demonstrate:

* A review of cleaning is undertaken and maintained to address the issues raised in the Assessment Team’s report.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 6(3)(c) Non-compliant

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

The approved provider must demonstrate:

* Complaints are documented with an evaluation of the outcome provided to consumers and representatives.
* Appropriate action is taken in response to complaints and open disclosure process is used when things go wrong.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 7(3)(a) Non-compliant

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

The approved provider must demonstrate:

* 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.
* Call bell data is analysed to measure whether its staff mix and allocation is sufficient to provide responsive delivery of safe and quality care and services to consumers when and where it is needed.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 7(3)(c) Non-compliant

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

The approved provider must demonstrate:

* The workforce is competent and the members of the workforce have the knowledge to effectively perform their roles.
* Staff have the required knowledge to provide safe and effective care and services to consumers, in areas ranging from use of correct slings for lifting consumers, to meeting privacy and confidentiality requirements, to knowing about the dysphasia dietary standards.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 7(3)(d) Non-compliant

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

The approved provider must demonstrate:

* Staff can demonstrate their knowledge and competence relevant to their role and responsibilities following completion of mandatory training.
* Staff are provided education and can demonstrate their knowledge in incident management and preventions.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 7(3)(e) Non-compliant

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

The approved provider must demonstrate:

* The service undertakes regular assessment, monitoring and review of the performance of each member of the workforce with performance criteria and goals specific to their roles.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 8(3)(a) Non-compliant

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

The approved provider must demonstrate:

* Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Consultative forums/committees for consumers recommence to engage consumers in delivery of care services.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 8(3)(b) Non-compliant

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

The approved provider must demonstrate:

* The clinical and organisational governance systems and processes are implemented.
* Clinical governance meetings are held regularly to ensure the service is accountable for the delivery of safe, inclusive and quality care and services.
* Data trends provided to the governing body is accurate.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 8(3)(c) Non-compliant

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

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

The approved provider must demonstrate:

* Recognised improvements to the current governance systems are implemented.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 8(3)(d) Non-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 approved provider must demonstrate:

* Effective risk management systems and practices are demonstrated.
* High impact and high prevalence risks associated with consumer care are being identified, monitored and managed in the areas of behavioural management, skin integrity and pain management; and clinical oversight is effective in these areas.
* Effective identification and response to incidents and SIRS incident reporting occurs.
* Risk assessment is consistently carried out and communicated to support consumers to live the best life they can.
* All incidents are recorded through the IMS, and reported incidents are consistently actioned and reviewed in a timely and effective manner.
* The risk management system reflects the care of consumers and address how high impact and high prevalence risks associated with the care of consumers are managed.
* Initiatives recorded in the Training Plan and Action Plan are implemented.

### Requirement 8(3)(e) Non-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 approved provider must demonstrate:

* The clinical governance framework demonstrates how clinical risk is identified and managed, how high impact and high prevalence risks are identified, and risk mitigation strategies evaluated to protect the health, safety and well-being of consumers.
* The clinical governance framework addresses the issues raised in the Assessment Team’s report.
* Initiatives recorded in the Training Plan and Action Plan are implemented.