Performance

Report

**1800 951 822**

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| Name of service: | St Joseph's House |
| Service address: | 22 Norman Street PORT PIRIE SA 5540 |
| Commission ID: | 6100 |
| Approved provider: | The Catholic Diocese of Port Pirie Inc |
| Activity type: | Site Audit |
| Activity date: | 14 March 2023 to 17 March 2023 |
| Performance report date: | 17 May 2023 |

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

**This performance report**

This performance report for St Joseph's House (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* the provider’s response to the Assessment Team’s report received 21 April 2023.

# Assessment summary

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

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

# Areas for improvement

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

**Standard 2 requirement (3)(e)**

* Ensure staff have the skills and knowledge to update assessments and care plans in response to consumers’ changing condition, care and service needs.
* Ensure care plan review processes include a detailed analysis of consumers’ health care issues for the previous month.
* Ensure care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g)**

* Ensure staff have the skills and knowledge to:
  + provide appropriate care relating to diabetes, weight loss and wounds;
  + initiate appropriate assessments, develop management plans and monitor effectiveness of management plans, including in relation to diabetes, weight loss and wounds;
* identify deterioration or change of consumers’ condition, implement appropriate monitoring processes and review care and service management strategies to ensure care provided is reflective of consumers’ changed condition;
* ensure Medical officers record and communicate instructions or recommendations following consumer review, including change of treatment;
* initiate timely and appropriate referrals to Medical officers and/or appropriate Allied health professionals in response to changes in consumers’ condition; and
* implement processes and practices to minimise infection related risks and promote appropriate antibiotic prescribing.
* Review information exchange processes to ensure sufficient, relevant and up-to-date information is provided to staff to enable appropriate delivery of care and services to consumers.
* Ensure the Infection register is maintained to enable effective monitoring of infection rates and antibiotic use and opportunities to minimise infection related risks to be identified.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, diabetes, weight loss, wounds and infection control are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, diabetes, weight loss, wounds and infection control.

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

* Ensure staff competency, skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training to address the deficiencies identified in four of the eight Quality Standards.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken and where poor staff performance is identified, ensure performance management processes are implemented promptly.

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

* Ensure the governing body is aware of and accountable for the delivery of care and services through review of communication and reporting processes from the service to the Board and vice versa.
* Review the organisation’s governance systems in relation to information management, continuous improvement and workforce governance.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks and managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to antimicrobial stewardship and monitoring of consumer infections, as well as in relation to the non-compliance identified in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care.

# Standard 1

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

Findings

All consumers and representatives sampled said consumers are treated with dignity and respect and their identity and diversity is valued. Assessment processes assist to identify consumers’ likes and dislikes and care files sampled were reflective of consumers’ background. Staff sampled were familiar with consumers’ backgrounds, needs and preferences and were observed treating consumers respectfully and in a dignified manner when providing care.

Consumers felt valued and safe when receiving care and services, said their culture is respected, and they are supported to maintain their identity. Consultation and assessment processes identify how consumers’ wish to be supported to maintain their culture, beliefs and traditions, and care files identified consumers’ backgrounds and strategies to support them. Policy and procedure documents outline how staff can support consumers to ensure cultural safety is maintained and staff were familiar with consumers’ specific cultural needs and described how they tailor care and services to meet those needs.

Consumers felt the service supports them to make decisions about their own care and representatives said they are involved in decisions about care and services when consumers are unable to communicate those decisions themselves. Care files included involvement of representatives and communication of consumer choices and staff gave examples of how they assist consumers make day-to-day choices and to access supports consumers’ need.

Consumers said they are supported to take risks which enables them to be independent and staff described how they support consumers to take risks. Where consumers are identified as partaking in an activity which includes an element of risk, Dignity of risk forms are completed in consultation with the consumer, which includes discussion relating to related risks and implementation of agreed upon strategies to mitigate risks. Allied health specialists are involved in assessment processes, as required.

Information is provided to consumers through a range of avenues, including emails, noticeboards, newsletters and consumer meeting forums. Consumers were happy with information communicated to them and said staff were very good at communicating information. There are processes to ensure consumers’ privacy is respected and personal information kept confidential. Consumer and employee handbooks include reference to consumers’ right to privacy and dignity and the importance of consumers’ personal information remaining confidential.

For the reasons detailed above, I find all requirements in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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

Findings

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(e)**

The Assessment Team were not satisfied consumers’ care and services are consistently reviewed for effectiveness when circumstances change or when incidents impact on consumers’ needs, goals or preferences. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Staff interviewed stated consumers’ assessments and care plans are reviewed and updated through the reassessment process and changes made when consumer’s needs change, however, stated some information is captured within numerous assessments and sometimes it is updated in one assessment but not correct in other assessments.
* Through Resident of the day processes, clinical staff are to review progress notes for the month, report vital signs outside the consumer’s reportable range and review the consumer’s picture care plan and liaise with the Registered nurse and/or Clinical nurse to adjust the care plan as needed.
* Progress notes for Consumer A’s Resident of the day reviews were completed in January and March 2023 but not for February 2023. The monthly analysis of health care issues completed in March 2023 states the consumer was commenced on antibiotics for cellulitis, however, medication charts show it was for a respiratory tract infection. The review indicates antibiotics were completed in February 2023 and the infection was resolved, however, progress notes showed the infection was ongoing. The review indicates a wound chart is in place, however, does not demonstrate the wound charts/treatment or progress of the wounds was reviewed during the Resident of the day process.
* Consumer B entered the service in March 2023. Completed assessments did not include goals of care or interventions.
  + Progress note dated March 2023 indicates medications are to be crushed until further notice. A Potential complications assessment/care plan dated seven days later states staff are to administer medications whole. The care plan/assessment referred to another consumer.
  + Progress notes dated March 2023 indicated the consumer’s’ diet and fluid texture was changed due to a choking incident. The Nutrition needs assessment/care plan dated 7 days later indicates the consumer’s diet type is normal.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a Plan for continuous improvement (PCI) outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Training related to documentation/care planning is planned to be completed by September 2023.
* Indicated Consumer B was referred to the Speech pathologist. Documents provided demonstrate this occurred five days post the choking incident, in line with dates outlined in the Assessment Team’s report. The response also indicates the consumer’s diet was downgraded on entry, however, this is not consistent with the Assessment Team’s report indicating this occurred five days later.
* The response did not address Resident of the day reviews for Consumer A.

I acknowledge the provider’s response. However, I find the service did not ensure care and services were effectively reviewed in response to incidents and changes in consumers’ care and service needs.

In coming to my finding, I have considered Resident of the day processes did not include a detailed summary or review of consumers’ health and/or condition over the previous month, or evidence review of the care plan and associated documentation, in line with the service’s processes. A Resident of the day review in March 2023 for Consumer A did not demonstrate a detailed analysis of health care issues for the previous month was undertaken. Inconsistencies in infection management and status were noted, as well as in relation to the consumer’s skin integrity. Consumer B’s assessments were not updated in response to the consumer’s changing condition. Management strategies for medication administration and nutrition and hydration documented on assessments was not congruent with progress note information, placing the consumer at potential risk. I find the inconsistencies in assessment and planning have the potential to impact on the effective delivery of care and services, particularly where staff delivering care are not familiar with consumers or their care and service needs.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**In relation to all other requirements in this Standard,** care files sampled demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care are completed on entry and on an ongoing basis. A range of risk assessment tools are also used to inform care planning. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop a care plan which incorporates each consumer’s needs, preferences, goals and strategies to manage identified risks. Charting is used to monitor specific care needs, such as pain, continence, sleep and behaviours, and evaluation of outcomes is used to inform the assessment and planning process. Consumers and representatives indicated the entry process had been comprehensive and staff had a good understanding of consumers’ care needs and preferences.

Consumers and representatives confirmed assessment and planning identifies and addresses consumers’ current needs, goals and preferences. Assessments included detailed individualised strategies and advance care planning, goals, needs and preferences. Care files demonstrated conversations with consumers in relation to advance care and end of life planning occur on entry, during regular care evaluation processes and as required. A care file sampled for one consumer included their wishes relating to advance care directives and specific preferences relating to end of life care, such as pain management, nutritional intake, repositioning and family involvement. Policies and procedures are available to guide staff in delivery of care at the end of life phase and care and clinical staff were aware of where to access information relating to consumers’ end of life directives.

Care files sampled confirmed consumers and their representatives are involved in assessments and planning of care and services on entry and on an ongoing basis, and demonstrated involvement of Medical officers and Allied health specialists in consumers’ care. Consumers and representatives described occasions where they had been consulted in relation to assessments, reviews and changes to consumers’ care and service needs following Medical officer and Allied health visits and felt informed of any changes or reviews of consumers’ care and service needs.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers, staff and others and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers on request. Care plans included detailed information and individualised strategies relating to each consumer’s goals, needs and preferences for personal, clinical and lifestyle aspects of care. Most consumers and representatives confirmed they are kept informed of any changes, incidents or updates to assessments and felt engaged in the care and services provided. Most representatives were aware of care plan documents and confirmed they were able to access the care plan if they wished.

For the reasons detailed above, I find requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

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

**Requirement (3)(a)**

The Assessment Team were not satisfied each consumer receives safe and effective personal and clinical care that is best practice and tailored to their needs, specifically in relation to diabetes, infections and weight loss. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Consumer C

* Blood glucose levels were out of range on 39 of 44 occasions between February and March 2023. Progress notes and associated documents did not show the Medical officer was notified in line with the Diabetic management plan The consumer has not been reviewed by a Medical officer in over three months.
* Clinical staff stated when the consumer’s blood glucose levels are above the desired range they administer as required insulin, however, do not inform the Medical officer.
* Consumer C has had an ongoing urinary tract infection since February 2023. While antibiotics have been prescribed on four occasions since February 2023, urine samples have only been sent for pathology testing on two occasions. Antibiotics were commenced on one occasion, prior to receiving pathology results. The Medical officer has not attended the service to review the consumer, and additional strategies were not undertaken to assist in the management of the infection.

Consumer D

* Consumer D has had a 6.2kg weight loss over a seven month period.
* A Speech pathologist assessment form was completed in December 2021 by a Registered nurse. The assessment indicates the last Speech pathology review occurred in January 2019. A nutritional assessment dated December 2022 indicates the last Dietitian review occurred in hospital in February 2021.
* A food and fluid intake chart for a 26 day period between February and March 2023 shows the consumer had minimal food intake, however, no referral to Allied health services has been initiated.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Training related to urinalysis is planned for completion by April 2023 and detecting and managing urinary tract infections by August 2023.
* Created a Urinary tract management Local work instruction which includes flowcharts for assessment and action.
* In relation to Consumer C, staff commenced non-medication related interventions, sent a specimen to pathology and contacted the Medical officer. Documentation to demonstrate these actions or commentary relating to blood glucose monitoring was not provided.
* Consumer D has been deemed end of life.

I acknowledge the provider’s response. However, I find for the consumers highlighted, safe and effective personal and/or clinical care that was tailored and optimised health and well-being was not provided.

In relation to Consumer C, I find Medical officer directives relating to diabetes management were not consistently followed to ensure Consumer C’s health and well-being was optimised. While blood glucose levels have been outside of desired range on 39 of 44 occasions, the Medical officer has not been notified, in line with the Diabetes management plan. The Medical officer had not reviewed the consumer in over three months. While I acknowledge Consumer C has possibly had ongoing urinary infections since February 2023, there is no further evidence provided to indicate changes to the consumer’s health and well-being have occurred which could be indicative of a urinary infection. I have, however, considered the practices evidenced do not demonstrate appropriate infection prevention measures are applied or appropriate promotion of antibiotic use and have considered this aspect in my finding for requirement (3)(g) in this Standard.

In relation to Consumer D, while food and fluid charting was implemented and weekly weighs were occurring, these actions were not effective in identifying weight loss and reduced oral intake. The consumer was noted to have a gradual loss of weight over a seven month period and minimal food intake was noted in the period the monitoring chart was in place. However, referral to appropriate Allied health services did not occur, with the last Dietitian review noted to have taken place in February 2021. The provider’s response indicates Consumer D has been deemed end of life, however, I have considered this was subsequent to the Site Audit, and appropriate and timely actions were not taken to address the gradual weight loss identified prior.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**Requirement (3)(b)**

The Assessment Team were not satisfied skin integrity and wounds are effectively monitored or managed, resulting in wounds being acquired at the service and wound deterioration. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer A returned to the service from hospital in December 2023 on antibiotics following a COVID-19 diagnosis and was still unwell with a continuing moist cough. A Care plan evaluation in January 2023, 23 days following return from hospital, indicated the Medical officer, who had not reviewed the consumer since their return to the service, was contacted for review. Progress notes indicate the Medical officer reviewed the consumer 23 days later. While the Medical officer requested a Podiatry review ‘as soon as possible’, progress notes demonstrated this had not occurred.
* Consumer A entered the service with unstageable pressure wounds. Wound records showed different findings from Registered and Enrolled nurses in relation wound appearance and surrounding skin. Signs of infection are noted throughout wound documentation, however, there is no evidence actions to address the infections were undertaken, including contacting the Medical officer for review or wound swabs.
* Medication charts show antibiotics were commenced for an infection in the wound in February 2023. Progress notes did not show additional swabs were completed following the course of antibiotics, although the wound still showed signs of infection.
* The Registered nurse stated if they discover slough, odours or signs of infection, a wound swab is completed and sent for pathology and the Medical officer is notified that a wound swab has been completed. The results take a week to confirm it is infected, the MO will commence consumer on antibiotics if feel the need.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, updated processes to encourage use of virtual/telehealth services for wound reviews when the Medical officer does not attend the service in a timely manner; and created a training plan inclusive of pressure area care, documentation, wound management and skin integrity.

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

I find appropriate and prompt actions were not taken following Consumer A’s return from hospital to ensure their changing needs were met and clinical risks minimised. I have considered that while Consumer A returned to the service following a hospital admission still showing signs of being unwell, review by a Medical officer did not occur until 23 days after Consumer A’s return. I have also considered staff practices have not ensured wounds are effectively monitored and assessed to enable wound progression to be tracked or that changes to wounds are effectively identified and actioned. Inconsistencies in wound description were noted in reviews undertaken by Registered and Enrolled nurses, and while wound records indicate the wound presented with signs of infection, as described by the Registered nurse, wound swabs were not taken, in line with the service’s processes.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**Requirement (3)(d)**

The Assessment Team were not satisfied deterioration or change in consumers’ mental health, or physical function is recognised and responded to in a timely manner. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Consumer A

* Documentation indicates Consumer A did not fully recover from COVID-19 which was contracted in December 2022. Progress notes show the consumer’s health started to decline in February 2023 and they were transferred to hospital. The consumer was identified with a leg infection and exacerbation of a chronic condition. Wound charting and progress notes state wounds still appeared infected throughout March 2023.
* A Medical officer review did not occur until 21 days later, at which time the consumer was noted as doing well. However, reduced oxygen saturations were recorded on two occasions on this day.
* A progress note eight days later indicated the consumer complained of shortness of breath, with medication administered. A short time later, the consumer stated they were not feeling well. Oxygen was applied above the recommended range for consumers with the specific chronic condition. There was no indication staff checked the consumer’s oxygen saturation levels prior to administration and progress notes did not identify the Registered nurse on call was contacted in relation to the consumer feeling unwell.
* Records did not demonstrate all care and clinical staff have had training in relation to oxygen administration for consumers with the specific chronic condition.

Consumer B

* An entry urinalysis in March 2023 was positive for blood and leukocytes, however, the Medical officer was not notified and no additional interventions occurred. Review by the Medical officer did not occur until 11 days after entry and there was no evidence they were notified of the positive urinalysis.
* A progress note in March 2023 indicates a representative was concerned about the consumer’s swallowing and lethargy. The consumer experienced a choking incident the following day with a change in diet initiated and clinical staff reported minimal diet intake. A referral was not sent to the Speech pathologist until six days after the initial concern was raised. A care plan dated in March 2023 shows Speech pathology details had been completed by staff without a review being undertaken.
* The Medical officer was contacted three days following the initial concern and notified the consumer was lethargic. The Medical officer stated the consumer was at risk of infection, including urinary and respiratory, and while staff advised the consumer did not have a cough, they did not mention the positive urinalysis. No additional monitoring of the consumer was undertaken.
* Six days after the Medical officer was contacted, the consumer was found unresponsive. Staff administered oxygen and attended vital observations, however, while oxygen levels were 92%, no additional vital observations were recorded. The Medical officer was contacted who informed staff the consumer would be palliative. The consumer was again found non-responsive the following day, and while vital signs were initially completed, no additional vital observation monitoring was undertaken.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Consumer B was diagnosed with a urinary infection with antibiotics completed prior to entry. The consumer was being monitored closely using an Acute care monitoring tool and staff had accessed telehealth to attempt to get an assessment and further treatment as the Medical officer advised they were not available.
* Reviewed an updated Local work instructions relating to issues identified.
* Created a Training plan, inclusive of consumer deterioration, documentation and weight management.

I acknowledge the provider’s response. However, I find changes or deterioration in Consumer A and B’s condition were not effectively recognised or responded to appropriately and/or in a timely manner.

In relation to Consumer A, I have considered early intervention was not taken to minimise impacts to the consumer’s health and well-being. As noted in requirement (3)(b) of this Standard, the consumer was not reviewed by the Medical officer, despite continuing to be unwell, until 23 days following return from hospital. Additionally, following return from a further hospital admission in February 2023 where an infection and exacerbation of a chronic condition were identified, a Medical officer review did not occur until 21 days later. I have also considered appropriate action was not taken in response to a change in Consumer A’s condition. Despite the consumer’s diagnosis of a chronic condition, oxygen saturations were not checked prior to administering oxygen, oxygen was applied well above the recommended range and the Registered nurse was not contacted in relation to the consumer’s changed condition.

In relation to Consumer B, despite the Medical officer indicating the consumer was at risk of urinary infections, results from a urinalysis were not reported to the Medical officer. Timely actions were not taken following concerns raised by the representative relating to the consumer’s swallowing and a choking incident, with referral for a Speech pathology review not initiated until six days later. Additionally, appropriate monitoring of the consumer’s condition was not undertaken following two occasions where the consumer was found unresponsive.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**Requirement (3)(e)**

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

* Consumers and representatives stated there has been a large turnover of staff and a lack of staff to provide adequate care consistently to consumers. Representatives stated staff can be very busy and they do not get informed of incidents in a timely manner.
* One representative stated in the past, strategies have been put into place to ensure staff are aware of the consumer’s needs, however, they are not followed now, and staff are not aware of them when asked.
* One representative stated they were informed of an incident that had occurred four days prior and not on the day it had occurred.
* Clinical and care staff stated:
* when they have time off, they are not informed of changes to consumers that have occurred, and need to find time to review all the progress notes to identify what has occurred;
* they do not receive handover for the consumers, however, some staff choose to stay behind after their shift to provide staff commencing on the next shift with information on what has occurred for the consumers within that area; and
* they do not have any meetings, therefore, are not always informed about things occurring within the service.
* Management stated the Medical officer does not communicate with staff and will often not attend the service to review consumers. The Medical officer does not normally document in progress notes for the consumers, or if they do it is normally under whichever staff members’ name that is logged into the computer system at the time.

The provider’s response included supporting documentation, a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Reminders to care staff of documented handover tools to ensure consistency of care.
* Care staff meeting held with additional meetings added to the meeting schedule.
* Medical officer log-in details reissued and Registered nurses given access to the electronic system to enable Medical officer passwords to be reset, if required.
* Updated the clinical handover tool and reviewed and updated Local work instructions.
* Training related to handover processes is planned for completion by May 2023.

I acknowledge the provider’s response. However, I find information about consumers’ condition, needs and preferences is not effectively communicated. In coming to my finding, I have placed weight on feedback from staff indicating they do not receive a handover from shift to shift, nor do they feel informed about what is happening at the service as staff meetings are not held. Consumers and representatives sampled also felt information exchange processes had been affected by staff turnover resulting in inconsistencies in provision of consumers’ care and timely notification of incidents. Additionally, I have also considered feedback from management demonstrating information exchange processes between the service and Medical officer are not sufficient. As such, I have considered that these practices do not ensure the workforce has sufficient information to enable coordination and delivery of safe and effective care or have sufficient understanding of consumers’ conditions to provide and coordinate care.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**Requirement (3)(g)**

The Assessment Team were not satisfied consumers’ infections are monitored and reviewed. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Management stated all consumers who are prescribed antibiotics for infections are captured on the Infection register, however, this was not evidenced in documentation viewed.
* Clinical staff were not able to describe antimicrobial stewardship principles. They stated whilst they undertake a dipstick analysis when urinary infections are suspected, they do not routinely undertake pathology when other infections are suspected. They indicated they inform the Medical officer, and it is at their discretion.

In coming to my finding for this requirement, I have also considered the following evidence, as well as the provider’s response, highlighted in requirements (3)(a), (3)(b) and (3)(d) in this Standard:

* Consumer C has had an ongoing urinary tract infection since February 2023. While antibiotics have been prescribed on four occasions since February 2023, urine samples have only been sent for pathology testing on two occasions. Antibiotics were commenced on one occasion, prior to receiving pathology results. Additionally, the Medical officer has not attended the service to review the consumer, and additional strategies were not undertaken to assist in the management of the infection.
* Consumer A commenced antibiotics in February 2023 for a wound infection. Although the wound still showed signs of infection, progress notes did not show additional swabs were completed following completion of the antibiotics,.
* An entry urinalysis in March 2023 for Consumer B was positive for blood and leukocytes, however, there was no indication the Medical officer was notified and no additional interventions were implemented. Review by the Medical officer 11 days after entry did not indicate the Medical officer was notified of the positive urinalysis.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Provided training to staff in relation to management of urinary tract infections;
* Created a Local work instruction and flow chart to provide better management of urinary infections, and added infection management and antimicrobial stewardship to the training schedule.
* Consumer B was diagnosed with a urinary infection with antibiotics completed prior to entry. The consumer was being monitored closely using an acute care monitoring tool and staff had accessed telehealth to attempt to get an assessment and further treatment as the Medical officer advised they were not available.

I acknowledge the provider’s response. However, I find staff practices did not ensure precautions were implemented to prevent and control infection or appropriate antibiotic use to reduce the risk of antimicrobial resistance effectively promoted. Pathology testing was not consistently undertaken prior to commencement of antibiotics for Consumer C, and while the consumer has had ongoing urinary infections since February 2023, additional measures to prevent or control infection have not been implemented. In relation to Consumer A, wound swabs and pathology testing has not been undertaken despite a wound presenting with signs of infection, as described by the Registered nurse, in line with the service’s process. In relation to Consumer B, despite the consumer completing a course of antibiotics prior to entry and the Medical officer indicating the consumer was at risk of urinary infections, the Medical officer was not informed of the results from a urinalysis completed on entry. Evidence presented in requirement (3)(d) of this Standard indicates Consumer B’s condition deteriorated in the 19 days post entry.

I have also considered that the service did not demonstrate that data is used to monitor infections and resolution rates and the effectiveness of the infection control and prevention program. While an Infection register is in place, all consumers prescribed antibiotics for infections are not logged. I find this does not enable effective monitoring and analysis of infection rates and antibiotic use to identify trends and opportunities to minimise infection related risks and reduce risk of increasing resistance to antibiotics.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**In relation to requirements (3)(c) and (3)(f),** staff described personal and clinical care provided to consumers during the end of life phase and said they have access to information relating to consumers’ advance care directives. A care file for a recently deceased consumer demonstrated the consumer was regularly monitored, and care was provided in line with consumer’s changing needs. Progress notes demonstrated involvement of the Medical officer, including in relation to management of pain to maintain comfort. Consumers and representatives said, a sample of care files demonstrated, discussions relating to advance care directives are undertaken on entry or during care consultation processes.

Care files generally demonstrated timely and appropriate referrals are initiated to individuals and other organisations when needed. Deficits identified in relation to referrals relate more broadly to the overall lack of effective care delivery and communication, and management of risk and deterioration, which has been considered in other requirements within this Standard. Staff described a range of organisations/providers involved in consumers’ care, including Medical officers and Allied health services, and consumers and representatives confirmed regular input from the multidisciplinary team, including Allied health professionals, when required.

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

# Standard 4

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

Findings

Consumers said they receive safe and effective services and supports for daily living that meet their needs, goals and preferences and optimises their independence, health, well-being. Care files sampled demonstrated consumers are assessed and care plans reviewed on a regular basis to ensure services and supports continue to meet their needs, goals and preferences. Care and clinical staff sampled described how they support consumers to achieve their daily living needs, goals and preferences, including through promotion of independence with activities of daily living. Consumers indicated their cultural and spiritual practices are acknowledged and observed and they are supported to attend mass, as well as celebrate specific cultural religious days, and consumers were observed being provided emotional support by staff.

Care files and activity attendance records sampled, and feedback from consumers confirmed consumers are engaged in activities of interest, are supported to maintain personal relationships, and are able to participate in the community within and external to the service. Lifestyle staff described how they work with other organisations, advocates, community members or groups to assist consumers to follow their interests and social activities, and to continue their community connections. An activity program, developed and tailored to consumers’ interests, is maintained and is monitored and adjusted, as required, based on consumers’ feedback. Consumers said they felt connected and engaged in meaningful activities that are satisfying to them.

Information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely referrals are initiated. Staff described systems and processes used to ensure accurate and up-to date information is effectively communicated to them and consumers and representatives were satisfied they are kept informed about consumers’ care and service delivery needs, and felt staff were aware of consumers’ preferences, supports and care needs.

All consumers sampled were satisfied with the quality, quantity and variety of meals provided and indicated they enjoy the food and have enough to eat. Meals are prepared in line with a four-week rotating menu and meals were observed to be appetising and well received by consumers. There are processes to regularly review the menu, including through monthly consumer meeting forums, with recent changes noted to have been made to the menu ordering process in response to consumer feedback.

Equipment required to support delivery of services was observed to be safe, suitable, clean and well-maintained. Preventative and reactive maintenance processes ensure equipment is maintained and records sampled demonstrated maintenance issues are addressed in a timely manner. Care staff described how they maintain equipment following use and how they report maintenance issues.

For the reasons detailed above, I find all requirements in Standard 4 Services and supports for daily living compliant.

# Standard 5

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

Findings

The service environment was observed to be welcoming and easy to navigate, spacious and included communal spaces and outdoor areas. Consumers were observed utilising communal spaces, engaging with visitors and other consumers. Consumers sampled described their ability to decorate, arrange and personalise their rooms with their own furniture, photographs and bedding which was observed by the Assessment Team.

The service environment was safe, clean, and well maintained with consumers able to move freely both indoors and outdoors. Cleaning and reactive and preventative maintenance processes ensure the environment, furniture, fittings and equipment are safe and well-maintained. Staff described how they report maintenance issues and hazards, in line with the service’s processes. Consumers confirmed they felt safe living at the service and were satisfied with cleaning and maintenance services. Overall, furniture, fittings and equipment were observed to be safe, clean, well maintained and suitable for consumers. Consumers said they felt safe when staff used equipment and it was appropriate for their needs and maintenance staff are quick to respond to any issues.

For the reasons detailed above, I find all requirements in Standard 5 Organisation’s service environment compliant.

# Standard 6

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

Findings

Consumers, family, friends, carers and others are encouraged and supported to provide feedback and make complaints. Staff described how they gather feedback from consumers, including asking them about their satisfaction with services or providing them with feedback forms to complete. Consumers and representatives felt confident to speak with staff and management to raise issues and knew where to find feedback forms and suggestion boxes.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry and brochures relating to feedback processes were observed to be displayed on information boards throughout the service. Staff said they receive training in complaints processes and described how consumers with diverse needs are supported to access language services and alternate communication processes.

Policy and procedure documents are available to guide staff practice with regard to managing feedback and complaints. Documentation sampled demonstrated appropriate action is taken in response to complaints and open disclosure principles are applied in response to adverse events. Staff described actions taken in response to complaints, indicating they attempt to resolve issues immediately, or escalate them to clinical staff for resolution. Overall, consumers and representatives said they have very few complaints, however, when they raise issues they are actioned in a timely manner and to their satisfaction.

The service demonstrated how feedback and complaints are reviewed and used to identify and drive continuous improvement. An electronic system is used to record and track complaints which are monitored and reviewed to identify opportunities for improvement.

For the reasons detailed above, I find all requirements in Standard 6 Feedback and complaints compliant.

# Standard 7

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

Findings

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

**Requirement (3)(c)**

The Assessment Team were not satisfied the workforce is competent or have the qualifications and knowledge to effectively perform their roles. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Staff competency is monitored through daily review of progress notes, walkarounds by management and Registered nurse, initial and annual competency assessments and review of incidents and audits.
* Daily progress note reviews are not documented and failed to detect omissions in clinical documentation and deficits in staff practices related to identifying deterioration, and management of infections, diabetes, medications and weights.
* Although management said they spend a lot of time on the floor, this is done in an ad hoc way, and observations were not recorded.
* Care files sampled demonstrated:
* Staff were not monitoring and responding to Consumer C’s out of range blood glucose levels in line with the Diabetes management plan or Local work instruction or appropriately manage infections.
* Registered and Enrolled nurses were recording different findings in relation to wound appearance; and oxygen saturation levels were not undertaken prior to administration of oxygen with oxygen applied above the recommended range.
* Management acknowledged the range of scheduled audits undertaken are predominantly focused on policy, do not include review of consumer files to ensure staff compliance with Local work instructions and preclude opportunities to identify deficits in staff knowledge and implementation of relevant training.
* Wound care is incorporated in the Assessment and care planning audit which was undertaken in October 2022 and includes positive responses.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Introduced new auditing tools, audit schedule and processes, with a focus on clinical outcomes.
* Created a Training plan and education relating to management of wounds, pain, urinary tract infections and infections have been included.
* Created and/or updated and disseminated to staff Local work instructions to ensure a consistent approach to specific areas of consumers’ clinical care.
* An audit of all wounds and infections is planned with follow-up with individual staff where gaps are identified.

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

In coming to my finding, I have considered while management and clinical staff described ways in which staff competence is monitored, these monitoring processes have not been effective in identifying deficits in staff skills, knowledge and competence. Outcomes for consumers highlighted in Standard 3 Personal care and clinical care indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 requirements (3)(a), (3)(b), (3)(d) and (3)(g), which have been found non-compliant, demonstrate consumers have not been provided care that is best practice, tailored to their needs or optimised their health and well-being, high impact or high prevalence risks have been effectively managed, appropriate action has been taken in response to changes in consumers’ condition or appropriate strategies to minimise and/or manage infections implemented. Deficits have been identified in provision of care relating to management of diabetes, weight loss, wounds, changes in consumers’ condition and infections. I have also considered the outcomes highlighted in Standard 2 Ongoing assessment and planning with consumers requirement (3)(e) demonstrates staff are not skilled or competent with undertaking assessments or comprehensive review processes, including in response to changes in consumers’ health and well-being.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**Requirement (3)(d)**

The Assessment Team were not satisfied processes and systems for recruitment and training, have been effective to deliver the outcomes required by these Standards. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Training schedules indicated all 18 clinical staff completed online wound care training and a wound assessment and management toolbox module in December 2022. The toolbox training did not record completion dates for staff listed. Deficits in wound care have been identified by the Assessment Team.
* Training schedules indicate all staff are up-to-date with training and clinical staff completed training in relation to high risk consumer care and deterioration. However, deficits in practice were identified by the Assessment Team.
* Management advised completion of toolbox sessions is monitored and records indicate all staff are up-to-date. Handover processes are used to re-enforce staff knowledge from toolbox sessions which occurs on an ad-hoc basis, however, are not documented.
* There is a planned education calendar which includes scheduled online and toolbox sessions, and there is a lot of on-site informal education and mentoring undertaken, however, this is not documented.
* Staff confirmed completion of annual training related to the Serious incident Response Scheme (SIRS) and elder abuse, as well as additional toolbox refreshers, and could describe escalation processes. However, suspected elder abuse and incidents were not always escalated in line with work instructions.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, created a Training plan to address the deficiencies identified in the Assessment Team’s report; created processes to capture ad hoc training; and provided education to staff on wound management, pressure area care and the deteriorating resident.

I acknowledge the provider’s response. However, I find the service did not adequately demonstrate processes to ensure the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. I have considered that while records and feedback from staff indicates staff have completed training related to wound care, assessment and management, high risk consumer care and deterioration, SIRS and elder abuse, deficits in relation these aspects of care have been identified with related requirements found non-compliant. I have also considered that while handover processes are used to reinforce staff knowledge from training delivered through toolbox sessions, this is not documented to enable identification of additional training opportunities to further develop staff skills and knowledge.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**Requirement (3)(e)**

The Assessment Team were not satisfied processes and systems to monitor and review the performance of each member of the workforce have been effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Performance appraisals are informed by self-evaluation, feedback and complaints, incident data, on-floor and progress note observations and training feedback.
* Clinical staff and management said they review progress notes daily and take appropriate action to follow up with staff who have outstanding tasks in the electronic care system. Progress notes are also reviewed Monday to Friday. Management said historically, clinical audits were undertaken, however, this was not occurring.
* Management said there is some hesitancy to performance manage clinical staff due to lack of staff availability of this cohort.
* Records indicate staff performance appraisals are up-to-date.
* Management said a staff member, who was suspended for allegations of neglect during the Site Audit, had a reputation for being intimidating and erratic towards consumers, however, this was past history and not current and they were not being performance managed.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, improved care staff performance appraisal documentation; performance management of the mentioned staff member is currently being undertaken; and created a Training plan which includes education relating to deficiencies identified in the Assessment Team’s report.

I acknowledge the provider’s response. However, I find ongoing monitoring of the performance of each member of the workforce was not demonstrated.

In coming to my finding, I have considered while management and clinical staff described ways in which the performance of staff is monitored, issues identified by the Assessment Team highlighted in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care have not been identified. I have also considered feedback from management who stated there was a hesitancy to performance manage clinical staff due to a lack staff availability in this cohort. As such, I find the evidence presented indicates the service’s ongoing monitoring of the workforce’s duties, responsibilities and performance is not effective to ensure the workforces’ overall ability to provide consumers’ with quality care and services.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

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

**In relation to requirements (3)(a) and (3)(b),** the service has processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. Staffing levels and mix are monitored through review of feedback and complaints data, call bell response times and direct observations of staff practice. Overall, staff said they had sufficient time to undertake tasks, however, two staff indicated when unplanned absences occur, or when care staff are moved to other roles, shifts are not backfilled, and staff have less time to spend with consumers. Overall, consumers felt there were enough staff to meet their needs, however, some consumers and representatives said staff turnover impacts the consistency of care, and when staff are busy, representatives indicated they are not always informed of incidents in a timely manner.

Most consumers and representatives said staff are kind, caring and respectful in their interactions and treat consumers well. They also indicated staff know consumers’ likes and dislikes which are catered for. Staff sampled were knowledgeable of consumers’ identity, culture and diversity and could describe how they deliver person centred care.

For the reasons detailed above, I find requirements (3)(a) and (3)(b) in Standard 7 Human resources compliant.

# Standard 8

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

Findings

The Quality Standard is assessed as non-compliant as four of the five specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied the organisation’s governing body is provided with sufficient information to enable them to determine whether care provided is safe and effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Management said although there is an annual audit schedule which includes clinical and non-clinical audits, audits undertaken are not fit for purpose, are more focused on policy review and do not require staff undertaking the audit to review consumer data and files to ensure policy and/or Local work instructions are followed, and high risks associated with consumer care identified in a timely manner.
* Deficiencies in relation to management of wounds, pain and infection related risks were not identified by clinical monitoring processes, and information presented to the Board was not presented in a format to alert them to deficiencies in practice, related risks and outcomes to consumer care.
* There is no wound audit and although total number of wounds is reported on a monthly basis to the Quality and Governance Committee, insufficient information is included to alert the Committee to wounds which are not identified, treated in accordance with wound management plans, healing within agreed treatment goal timeframes, and referred to wound care experts or Medical officers.
* Management said although the Board is informed about the number of SIRS incidents and provided with a brief description, these are not always discussed in detail as they are considered more operational, and the Board is more strategic. Review of incidents is by internal audits, feedback, calls from the Commission and discussions with managerial staff and are not discussed at Quality and Governance Committee meetings.
* A Board member sits on the Quality and Governance Committee and are a conduit to the Board in identifying and highlighting risk. Meeting minutes indicate information is provided in relation to falls, behaviours, wounds, infections, medications and transfer to hospital. However, information presented is summarised data and management acknowledged this does not include trend analysis, risk identification or mitigation strategies related to consumer care.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Amended Quality and Governance Committee meeting minutes to ensure information presented at the meeting is captured.
* Revised the Board report for the Service manager to provide an overview of risks and include clinical governance, human resources, consumer advisory and Quality and Governance.
* Updated the directory of management meetings Local work instructions to include specific documents used to communicate current risk states of services, responsibilities of specific governing committees in reporting to the Board and communication back from the Board.

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

In coming to my finding, I have considered that reporting processes from a service and organisational level to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services.

While information related to a range of clinical indicators is discussed at organisational meeting forums, data presented is summarised and does not include trend analysis, risk identification or mitigation strategies related to consumer care. Additionally, the service’s own monitoring processes, including audits, have not been effective in identifying deficiencies in clinical care, therefore, not ensuring accurate data is presented and considered at an organisational and Board level. I find deficits in reporting has not ensured the governing body has sufficient oversight of the service’s performance to enable improvements to the quality of care and services to be identified. Systemic issues have been found in relation to provision of clinical and personal care and human resource management. I have considered such practices do not ensure the governing body is aware of whether it is meeting what consumers, the workforce and others expect for safe, inclusive and quality care and services from the organisation.

I have also considered that the findings of non-compliance in relation to 13 requirements across four of the eight Quality Standards indicates the governing body may not sufficiently understand their responsibilities as they relate to monitoring and improving the performance of the organisation against the Quality Standards.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes and improved consumer outcomes.

In relation to auditing tools and processes, I consider the evidence relates to continuous improvement processes. As such, I find the evidence is more aligned with requirement (3)(c) in this Standard and have considered it with my finding for that requirement.

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

**Requirement (3)(c)**

Effective organisation wide governance systems relating to financial governance, regulatory compliance and feedback and complaints were demonstrated. However, the Assessment Team were not satisfied organisation wide governance systems and processes relating to information management, continuous improvement and workforce governance were effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Information management

* Information management systems and processes were not effective to provide members of the workforce access to information that assists them in their roles and to appropriately analyse and manage risk.
* Medical officer notes are not recorded and clinical staff said they do not know what the Medical officer is doing unless they do rounds with them. Documentation viewed confirmed Medical officer notes are not recorded.
* A clinical handover Local work instruction outlines the requirement for handovers to have a verbal component wherever possible. Care staff reported they no longer do handover to each other at morning shifts. Management said care staff are provided with relevant information from handover processes undertaken by clinical staff.
* Care staff reported they do not have staff meetings and rely on information provided to them by clinical staff or by reviewing care plans. Management said care staff are not paid to attend staff meetings, so attendance is poor.

Continuous improvement

* All opportunities for continuous improvement are not effectively identified through internal mechanisms, such as review of practices and incidents, and where issues and risks have been identified, these are not included on the PCI.

Workforce governance

* The service was not able to demonstrate staff were always trained or provided with guidance to equip them with the knowledge to perform in their roles, with systems in place to monitor staff competency and ensure their performance is regularly monitored and reviewed.

In coming to my finding for this requirement, specifically continuous improvement, I have also considered the following evidence, and the provider’s response, highlighted in requirement (3)(b) in this Standard:

* Management said although there is an annual audit schedule which includes clinical and non-clinical audits, audits undertaken are not fit for purpose, are more focused on policy review and do not require staff undertaking the audit to review consumer data and files to ensure policy and/or Local work instructions are followed, and risks associated with consumer care identified in a timely manner.

The provider’s response included commentary relating to the deficits identified by the Assessment Team, as well as supporting documentation and actions taken in response. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to:

* Reminders to care staff of documented handover tools to ensure consistency of care.
* Medical officer log-in details reissued and Registered nurses given access to the electronic system to enable Medical officer passwords to be reset, if required.
* Updated the clinical handover tool and reviewed and updated Local work instructions.
* Introduced new audit tools and created and audit schedule and processes.
* Care staff meeting held and additional meetings added to the schedule.
* Updated the PCI to include all opportunities for continuous improvement.
* Education relating to the content of specific Local work instructions added to the training schedule.

I acknowledge the provider’s response. However, I find effective organisation wide governance systems relating to information management, continuous improvement and workforce governance were not demonstrated.

I find that information used by staff to guide provision of care and services was not available or up-to-date. Information in care plans sampled was either not up-to-date or reflective of consumers’ current care needs and preferences or did not include sufficient information relating to management strategies to guide staff with provision of consumers’ care and services. I have also considered care staff meetings are not consistently held; handover processes to care staff between shifts are not effective; and Medical officers do not consistently document in care files following review of consumers. I find such practices do not ensure sufficient exchange of information relating to consumers’ care and services. Furthermore, data, including in relation to infections and clinical incidents, is not being effectively collected to enable accurate trending, analysis and reporting to occur or improvements in the provision of care and services to be identified at an individual, site or organisational level.

I acknowledge a PCI is maintained and tabled at relevant meetings for review and approval. However, audit tools are not fit for purpose, focussing on policy, rather than consideration of consumer care files and care and service provision, and while other avenues to identify improvements, such as data collection related to infections and clinical incidents are undertaken, data presented in meeting minutes is not analysed for trends to enable improvement opportunities at both a service and organisational level to be effectively identified. Furthermore, I have considered the findings of non-compliance in relation to 13 requirements across four of the eight Standards indicates deficiencies with the governance processes associated with continuous improvement.

In relation to workforce governance, I have considered that evidence provided in the Assessment Team’s report in relation to Standard 7 demonstrates the organisation’s workforce governance systems are not effective. Three of the five requirements in Standard 7 have been found non-compliant. I find the organisation’s processes have not ensured the workforce is competent, or supported to deliver safe and quality care and services to consumers. I have also considered deficits highlighted across four of the eight Quality Standards indicates the organisation’s processes to monitor and review the performance of each member of the workforce have not been effective.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes, staff competency and improved consumer outcomes.

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

**Requirement (3)(d)**

The Assessment Team were not satisfied effective risk management systems and practices relating to high impact or high prevalence risks, identifying and responding to abuse and neglect, and management and prevention of incidents were demonstrated. The Assessment Team’s report did not specifically reference systems and practices to support consumers to live the best life they can under this requirement. However, I have relied upon evidence highlighted in other Standards and requirements, specifically Standard 1 Consumer dignity and choice requirement (3)(d) which demonstrates effective processes are in place to support consumers to live their best life. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

Managing high impact or high prevalence risks

* Policies and Local work instructions available to guide staff in managing deterioration, skin integrity and skin tears, wound care, reporting and documenting clinical incidents and pain management, were not consistently followed and monitoring and/or follow up by the service has not been established to ensure escalation occurs.
* There is a range of clinical and non-clinical audits which are part of an annual schedule. However, management said audits are not effective, as they are broad, focused on what the policy is for and do include a review of consumer information to determine if Local work instructions are being followed.
* Identifying and responding to abuse and neglect.
* Although the organisation has a Minimising potential harm policy which outlines a range of practices and processes to reduce likelihood of potential harm related to specific areas of care, this was not consistently effective to identify risks associated with care for specific consumers. High risk consumer meetings are conducted to discuss consumers with complex health needs, incidents of concern and change of health status. However high-risk consumers are not always identified and discussed in relation to hospital admissions and discharge and Local work instructions are not always followed by staff or identified through monitoring processes.
* Effective monitoring of consumers who have ongoing infections was not demonstrated. Several consumers have had several courses of antibiotics which has not been identified or discussed in clinical documentation or alternative antibiotics trialled.

Managing and preventing incidents

* While the organisation has policies to guide staff in relation to reporting and documenting incidents, documentation sampled indicated not all incidents are reported in a timely manner and insufficient information was recorded to enable incidents to be identified and responded to improve quality of care and services.
  + Consumer D’s representative was advised the consumer was involved in an incident in March 2023, however, this was not reported by another care staff until four days after the incident occurred. Management reported the staff making the allegations was hesitant to report due to potential repercussions from the staff involved. A SIRS report was completed during the Site Audit.
* Information provided to the Quality and Governance Committee includes data related to incidents, such as falls, near misses, behaviours, wounds medications, hospital transfers and weight. However, an analysis of data presented or trends identified is not included.
  + Falls data does not identify whether falls and near misses relate to recurrent fallers, include identification of reasons for falls or risk mitigation strategies.
  + Wound data does not identify if wounds have been recurrent, long-standing, nor at what stage they were identified and infections do not capture if these are long-standing or if antibiotics have been commenced and effective.

In coming to my finding for this requirement, I have also considered the following evidence, as well as the provider’s response, highlighted in Standard 7 requirement (3)(c):

* Management acknowledged wound audits have not been undertaken and the current range of scheduled audits are predominantly focused on policy and do not include review of consumer files to ensure staff compliance with Local work instructions, precluding opportunities to identify deficits in knowledge and implementation of relevant training.
* Wound care is incorporated in the Assessment and care planning audit which was undertaken in October 2022 and includes positive responses.

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

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

I have also considered that management and staff have not demonstrated an understanding and application of their own incident reporting and escalation processes. Not all consumer incidents had been reported, including in a timely manner to consumers’ representatives, insufficient information was captured to enable incidents to be identified and effectively responded to and timely reporting through the SIRS had not occurred for the incident highlighted. I have also considered incident data is not analysed to assist to identify trends and opportunities for improvement or to ensure risks to consumers’ health and well-being are minimised and/or eliminated.

I have considered the evidence presented in this requirement does not demonstrate systemic deficits with the clinical governance framework as it relates to identifying and responding to abuse and neglect. I have also considered evidence related to infections and antibiotic use is more aligned to antimicrobial stewardship practices. As such, I find this evidence is more aligned with requirement (3)(e) in this Standard and have considered it with my finding for that requirement.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes, staff competency and improved consumer outcomes.

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

**Requirement (3)(e)**

The Assessment Team were not satisfied an effective clinical governance framework, inclusive of antimicrobial stewardship and minimising use of restraint was demonstrated. The Assessment Team’s report did not specifically reference open disclosure under this requirement. However, I have relied upon evidence highlighted in other Standards and requirements, specifically Standard 6 Feedback and complaints requirement (3)(c) which demonstrates open disclosure principles are applied when things go wrong. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* High risk consumer meetings did not outline interventions put in place, measure effectiveness or outline alternatives for risks related to consumers’ care.
* Quality and Governance Committee meetings did not identify risks associated with recurring infections for three consumers which were not recognised or responded to in a timely manner.

Antimicrobial stewardship

* The Local work instruction outlines a number of audits to be completed related to antimicrobial stewardship, however, these have not identified antibiotics being prescribed without pathology reports for all consumers.
* Although clinical staff demonstrated knowledge about reduced effectiveness of antibiotics for more than two courses, documentation indicates some consumers have had more than two courses of antibiotics, which were not reviewed for effectiveness or alternative strategies trialled as required by the Local work instruction.
* Clinical monitoring processes, such as high-risk consumer, Resident of the day and Medication Advisory Committee meetings have not been effective in identifying multiple use of antibiotics or ongoing use of antibiotics for some consumers.

Restrictive practices

* Management reported restrictive practices are reviewed monthly, however, no documented audit is conducted, and audit tools being utilised by the organisation are being reviewed.
* Management stated consumers have access to codes for pin-code operated doors. On two occasions doors were locked. Some staff said these doors are often locked, however, management said they were locked due to a fire drill.

In coming to my finding for this requirement, I have also considered the following evidence, as well as the provider’s response, highlighted in Standard 3 requirement (3)(g):

* Management stated all consumers who are prescribed antibiotics for infections are captured in the Infection register, however, this was not evidenced in documentation viewed.

The provider’s response included actions taken and/or planned in response to the deficits identified by the Assessment Team, as well as supporting documentation. The response also included a Training plan and a PCI outlining planned actions, planned completion dates and outcomes to address the deficits identified. The provider’s response included, but was not limited to, introduced new auditing tools, audit schedule and processes, with a focus on clinical outcomes; reviewed and updated related Local work instructions; and planned training related to antimicrobial stewardship and restrictive practices to be completed by April 2023.

I acknowledge the provider’s response. However, I find the organisation’s clinical governance framework was not effective. While I find effective systems were demonstrated in relation to open disclosure and restrictive practices, I consider systems relating to antimicrobial stewardship are not effective.

I have considered that while an Infection register is available, this register was found not to include all consumers identified with an infection and prescribed antibiotics. As such, the data collected through the register is not accurate making monitoring of infection rates and antimicrobial use difficult. I find this has not ensured an effective system to prevent, manage and control infections and antimicrobial resistance is maintained to assist to identify trends and opportunities to improve the care and services delivered. I have also considered pathology testing prior to commencement of antimicrobials is not routinely undertaken. I find such processes do not ensure effective prevention, management or control of infections and antimicrobial resistance or that antimicrobials are prescribed in line with best practice guidelines.

I have considered the evidence presented does not demonstrate systemic deficits with the clinical governance framework as it relates to minimising the use of restraint. While there are no audit tools related restrictive practices, the Assessment Team’s report indicates use of restrictive practices is monitored and reviewed on a monthly basis. Standard 3 Personal care and clinical care does not include any reference or deficits relating to restrictive practice use for individual consumers.

I have also considered the findings of non-compliance in one of the five requirements in Standard 2 Ongoing assessment and planning with consumers and five of seven requirements in Standard 3 Personal care and clinical care. The findings in these Standards and the evidence presented in this requirement indicates the organisation’s clinical governance framework is not effective, with deficits highlighted not being identified by the service’s or organisation’s own monitoring processes.

I acknowledge the provider has submitted a PCI to remedy the deficits in this requirement and planned completion dates have been set. However, I consider that the planned completion date for the improvement activities planned and/or implemented in relation to this requirement is noted as October 2023, therefore, time will be required to establish and embed processes, staff competency and improved consumer outcomes.

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

**In relation to requirement (3)(a),** most consumers and representatives felt engaged in the development, delivery and evaluation of care and services through care planning meetings, feedback processes, surveys and consumer meeting forums. A Consumer Advisory Committee to the Board is being established to create links between consumers and the Board and one consumer spoke of their involvement in the development and implementation of this initiative. Consumers and representatives sampled said they provide feedback in relation to care and services, including at meetings and through ongoing discussions with staff which influence the services consumers receive.

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

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