Performance

Report

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| Name of service: | Treeby Parklands Care Community |
| Service address: | 5 Abelia Road TREEBY WA 6164 |
| Commission ID: | 7424 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 27 June 2023 to 29 June 2023 |
| Performance report date: | 5 September 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 Treeby Parklands Care Community (**the service**) has been prepared by M Dubovinsky, 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 staff, consumers/representatives and others; and
* the Approved Provider’s response to the Assessment Team’s report received 28 July 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 | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

## Standard 2 Requirement (3)(a)

* Review relevant policies and procedures to support assessment and planning including in relation to risk assessments and development of effective strategies for consumers who choose; to lock their door, consume meals outside of clinical recommendations or self-administer their own medications.
* Ensure staff undertake risk assessments which consider strategies to support consumers and specifically in relation to managing risks associated with choking, self-medicating and for consumers who choose to lock their doors.

## Standard 2 Requirement (3)(e)

* Review relevant policies and procedures to support regular assessment and review of care and services including for consumers who return from hospital including when changes are made to dietary requirements and technical nursing needs such as oxygen therapy, following changes to self-medication assessments, and where strategies are trialled such as in relation to the provision of personal hygiene that they are evaluated for effectiveness.
* Ensure consumers who return from hospital are effectively reviewed with recommendations effectively implemented. For consumers who have a decline in ability to self-medicate ensure relevant assessments are reviewed. Ensure processes support the regular review of assessments including assessments being completed in relation to life events.

## Standard 3 Requirement (3)(a)

* Review relevant policies and procedures to support the delivery of tailored and best practice personal and clinical care, specifically for consumers in relation to diabetes management, oxygen therapy management, post fall monitoring and safe medication management.
* Ensure medications are administered consistent with best practice and policies and procedures.
* Ensure effective behaviour support strategies are undertaken to support the provision of effective personal care.
* Ensure staff seek medical input when short course medications are not administered and undertake follow up action following near miss medication incidents. Ensure staff undertake relevant monitoring of consumers following falls, and in relation to specialised nursing needs such as for consumers who have diabetic or oxygen therapy care needs.

## Standard 3 Requirement (3)(b)

* Review relevant policies and procedures to support effective management of high-impact and high-prevalence risks associated with each consumer.
* Ensure staff follow falls management strategies, effectively review strategies following the identification of pressure injuries, implement strategies to manage consumers’ risk of malnutrition and ensure person centred alternative strategies are trialled prior to the administration of high-risk medications in the context of behaviour support.

## Standard 3 Requirement (3)(f)

* Review relevant policies and procedures to support timely and appropriate referrals in relation to behaviour support and weight management.
* Ensure staff recognise and undertake timely referrals consistent with internal policies and procedures and their practice monitored.
* Ensure where weight loss is identified or where behaviour support is ineffective staff consider referring consumers to other health professionals.

## Standard 6 Requirement (3)(c)

* Review relevant policies and procedures to support appropriate action being taken in response to complaints and open disclosure being practiced.
* Ensure staff recognise feedback, use feedback management processes, and undertake open disclosure where required and following incidents.
* Ensure when staff undertake open disclosure as part of incident management, relevant documentation is completed to support effective monitoring.

## Standard 7 Requirement (3)(c)

* Ensure staff practices are monitored to ensure staff competence including in relation to open disclosure and actioning feedback, assessment and planning and delivering personal and clinical care in relation to medication management including high-risk medications, behaviour support, falls management, specialised nursing needs, incident reporting and timely referrals.
* Review relevant policies and procedures to support staff in effectively perform their roles to ensure competence in deficits identified.

## Standard 8 Requirement (3)(d)

* Ensure staff are recognising and reporting incidents through the incident management system.
* Ensure clinical indicator data is being effectively reviewed to improve the delivery of care for consumers including in relation to managing falls, effective use of high-risk medications and managing malnutrition.
* Review relevant policies and procedures to support effective risk management systems and practices, specifically in relation to monitoring and managing high-impact or high-prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management system.

## Standard 8 Requirement (3)(e)

* Ensure the service understands their responsibilities in relation to restrictive practices and behaviour support in accordance with the Quality of Care Principles 2014.
* Review the organisation’s clinical governance framework, specifically in relation to minimising use of restrictive practices and open disclosure. Review governance processes to monitor and address the non-compliance identified.

# 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

The service was found non-compliant with Requirement (3)(a) following a Site Audit conducted from 19 April 2021 to 21 April 2021 where it was found the service was unable to demonstrate consumers’ were treated with dignity and respect with consumers observed dressed and walking in an undignified manner, staff assisting consumers in an undignified manner with meals and representative concerns in relation staff ignoring consumers. The Assessment Team’s report did not include improvements implemented in response to the non-compliance.

At the Site Audit in June 2023 the Assessment Team recommended Requirements (3)(a) and (3)(d) not met. However, for both Requirement I have come to a different view to that of the Assessment Team and have include my reasoning under the specific Requirement below.

## Requirement (3)(a)

At the Site Audit in June 2023 the Assessment Team recommended Requirement (3)(a) in this Standard not met as the service was not able to demonstrate each consumer is treated with dignity and respect with their identity culture and diversity valued, specifically in relation to the provision of meal services, ensuring consumer privacy is maintained and agency staff not being familiar with consumers and their care needs. The following evidence was considered relevant to my finding;

* Consumer A stated there is a high turnover of staff and as a result staff do not know them or what is important to them as they have to repeat themselves. In addition, Consumer A’s documentation stated the consumer likes to argue and can be rude.
* Consumer B stated they have a do not disturb sign, however staff continue to disturb them during the night which they have raised as an ongoing issue and has not been resolved. Other than this one issue they are satisfied staff treat them well.
* Consumer C stated regular staff know them and are treated with dignity and respect.
* Five workers who were students, agency or non-regular staff were not aware of other consumers by name or able to provide examples of how they treat consumers with dignity and respect.
* Consumer E was observed during meal service to be eating their meal with two butter knives. Staff intervened and provided two spoonful’s before walking away with no interaction. Consumer D was also observed during lunch to be by themselves eating a meal with their hands which required utensils. Staff stated both consumers were sitting by themselves as the consumers they were sitting with had recently passed away.
* During a subsequent meal service Consumers D and E were observed to be seated at the table or in close proximity.
* Management stated staff were provided training on dignity and respect through their orientation process.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Consumer A’s care plan was reviewed to ensure dignified language and acknowledged the challenges of having a diverse workforce.
* Acknowledged a recent recruitment drive with new students on their first week at the time of the Site Audit.
* Reviewed the close circuit television (CCTV) camera footage and found the meal service reflected consumers were being treated with dignity and respect. Consumer E had reached across to an adjacent consumer and took their cutlery and was treated with dignity and respect with staff speaking to them and was assisted. The Provider asserts Consumer D requires supervision with intake and occasional hands-on assistance and the consumer was supported and assisted after the Assessment Team left.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I have come to a different view and find the service was able to demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

In relation to Consumer’s D and E, I have considered the information in the Assessment Team’s report that shows observations made on the subsequent day which showed both consumers were seated at or near a table to promote their dignity and accept the further evidence provided in relation to the provision of meal services and associated supports required for both consumers. I have also considered evidence documented in Standard 4 Requirement (3)(f) that indicates overall consumers socialising and eating their meals and staff being observed interacting with consumers in a polite manner. I have also considered evidence documented in Standards 7 Requirement (3)(b) where consumers were satisfied they were treated with dignity and respect and staff were able to describe examples of how they practice day to day respectful care and were observed throughout the Site Audit interacting with consumers and their families in a kind and respectful manner. I have also considered regular staff treating consumer C with dignity and respect.

In relation to Consumer B and staff disturbing them at night despite having signage on their door, I have considered the evidence documented in Requirement (3)(f) in this Standard with the evidence stating consumers were satisfied their privacy was being respected. I have also considered overall Consumer B was satisfied staff treat them well.

In relation to Consumer C, I have placed weight and considered the evidence indicating the consumer is treated with dignity and respect by regular staff and measures undertaken by the Approved Provider to address the documentation for Consumer A to ensure dignified language when documenting.

Based on the information summarised above, I find Requirement (3)(a) compliant in Standard 1 Consumer dignity and choice.

## Requirement (3)(d)

The Assessment Team recommended Requirement (3)(d) in this Standard not met as the service was not able to demonstrate each consumer is supported to take risks to enable them to live the best life they can, specifically the development of strategies to manage potential risks whilst supporting consumers to live their best life. The following evidence was considered relevant to my finding;

* Consumer F had a completed dignity of risk form for no overnight checks, however, was not aware of being involved in discussions. Consumer F stated the purpose of locking the door was to prevent another consumer from entering but wished to have staff check on them due to a recent fall. In addition, Consumer F was not informed of risks associated with drinking alcohol and the consumer was being provided non-alcoholic beverages.
* Consumer C has a diagnosis associated with a swallowing impairment and the consumer has chosen to consume a diet outside of recommendations made. Whilst a dignity of risk form was completed there were no strategies to manage the risk of harm and all staff interviewed were unsure of strategies used.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Asserts Consumer F has a diagnosis impacting their memory, and relevant consultation had occurred with the consumer and documented in their dignity of risk of assessment. Progress notes provided showed staff recorded the consumer’s preference for the consumer not to be disturbed during night shift. Assert the consumer was involved in decision making with a dignity of risk form provided outlining the consumer being informed of the risks associated with drinking alcohol.
* Asserts Consumer C had a dignity of risk form completed which outlined the risk of choking which was supplied in the response. Whilst the form showed the consumer was informed of risks associated with choking, the form does not outline strategies to mitigate potential harm. Progress notes confirm the representative and the consumer confirming they were informed of the risks and signed a dignity of risk form.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was able to demonstrate each consumer is supported to take risks to enable them to live the best life they can and specifically for Consumers F and C.

In coming to my finding for Consumer F, I have considered the evidence which shows the consumer was supported in their choice for having their door locked as per their request. Whilst the consumer has since changed their preference for having their door locked, I have considered the service has supported the consumer in their preference for having their door locked with relevant assessment and planning completed to enable them to live the life they choose. In addition, I have noted the consumer had a relevant assessment and plan to support them in choosing to consume alcohol and the consumer was informed of relevant risks.

In coming to my finding for Consumer C, I have considered the evidence which showed the consumer and representative were informed of the risks associated with eating a diet outside of recommendations and were supported in that choice. Whilst evidence to demonstrate additional strategies were developed was not provided, I have considered this deficit in my finding for Standard 2 Requirement (3)(a) and specifically consideration for the consumer’s risk of aspiration and choking and relevant assessment and care planning not being completed.

Finally, I have considered the evidence which showed most consumers were being supported to make decisions about their care and services, including when their choice involved an element of risk.

Based on the information summarised above, I find Requirement (3)(d) compliant in Standard 1 Consumer dignity and choice.

**In relation to all other Requirements**, the service demonstrated care and services provided to consumers are culturally safe. Regular directly employed staff working in their respective areas knew consumers’ preferences and management could demonstrate how they provide culturally appropriate care. The service has a cultural safety, diversity and inclusion policy to support staff in their roles and staff are provided training as part of onboarding.

Consumers are supported to exercise choice and independence and make decisions with respect to their care provision. Couples are supported to maintain intimate relationships and documentation viewed showed consumers and representatives are supported in decision making. A range of methods are used to ensure the provision of current, accurate and timely information to consumers and their representatives to exercise choice. This includes a monthly newsletter, noticeboards and welcome pack information and aids to support consumers who have hearing deficits.

Overall, consumers’ privacy is respected and personal information is kept confidential. Some consumers expressed dissatisfaction and have chosen to have their doors locked to maintain their privacy which was considered in Standard 2 Requirement (3)(a) as the deficits related to effective assessment and planning in the context of managing risk. Majority of Consumers interviewed reported that they have no concerns regarding their privacy and confidentiality being maintained by the service and staff were observed to knock on consumers’ doors and wait for a response prior to entering.

Based on the information summarised above, I find the service compliant with Requirements (3)(b), (3)(c), (3)(e) and (3)(f).

# Standard 2

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

I have assessed the Quality Standard as non-compliant as I am satisfied Requirements (3)(a) and (3)(e) are non-compliant.

The service was found non-compliant with Requirement (3)(e) following a Site Audit conducted from 19 April 2021 to 21 April 2021 where it was found the service was unable to demonstrate care and services were effectively reviewed in relation to falls. In addition, pain was not always effectively reviewed following incidents of changed behaviours. The Assessment Team’s report did not include improvements implemented in response to the non-compliance.

At the Site Audit in June 2023 the Assessment Team recommended Requirements (3)(a), (3)(b) and (3)(e) not met. However, for Requirement (3)(b) I have come to a different view to that of the Assessment Team and have include my reasoning under that specific Requirement below.

## Requirement (2)(a)

The Assessment Team recommended Requirement (3)(a) in this Standard not met as the service was not able to demonstrate relevant assessment and planning was completed and risk mitigation strategies developed for consumers who choose to have their doors locked and for one consumer who self-medicates a high-risk medication. The following evidence was considered relevant to my finding;

* Four consumers had dignity of risk forms developed, however risk mitigating strategies were not documented. Consumer J stated they lock their door at night for privacy, however a risk assessment was not completed, and management identified 11 consumers who did not have relevant assessment and planning completed.
* Consumer H has a self-medication assessment to self-administer their medication. However, the form does not provide sufficient guidance or strategies.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* A self-medication assessment was provided for Consumer H dated three months prior which identifies the medication being self-administered. However, no further strategies are developed. The response asserts they were not aware of any significant decline in the consumer’s condition impacting their ability to self-administer.
* Acknowledged a plan for continuous improvement was commenced during the site audit to ensure relevant assessment and planning was undertaken in relation to the privacy locks.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate relevant assessment and planning including consideration of risks for 11 consumers who choose to lock their doors, for Consumer H in relation high-risk medication and Consumer C in relation to risk of choking.

In relation to Consumer H, I find relevant assessment and planning was not undertaken specifically in relation to risks associated with high-risk medication. In coming to my finding, I have noted the self-medication assessment which did not show relevant assessment and planning to support the consumer in self medicating a high-risk medication with sufficient guidance. I have also considered evidence in Requirement (3)(e) in this Standard where staff were administering the consumer’s medication following a decline in their condition which is inconsistent with the self-medication assessment.

I find the service did not undertake relevant assessment and planning for 11 consumers who choose to have their doors locked and acknowledged the planned improvements which were commenced during the Site Audit.

I have also considered evidence documented in Standard 1 Requirements (3)(d) where Consumer C did not have a relevant assessment completed and strategies developed to manage the consumer’s risk of choking with staff not being aware of relevant strategies.

Based on the information summarised above, I find Requirement (3)(a) non-compliant in Standard 2 Ongoing assessment and planning with consumers.

## Requirement (3)(b)

The Assessment Team recommended Requirement (3)(b) in this Standard not met as the service was not able to demonstrate assessment and planning including advanced care planning and end of life planning is routinely commenced on admission and two consumers did not have relevant information documented in relation to life events and personal hygiene preferences. The following evidence was considered relevant to my finding;

* Ten from 13 consumer files viewed did not have end of life planning completed with management stating they ask at every care conversation and will often ask when consumers are on a palliative trajectory and provided a blank care conversation to demonstrate the practice.
* The service had recently completed an audit and created an alert if the consumer had an advanced care plan.
* Consumer K had a trial for personal hygiene to be attended to in the morning in place, however care planning documentation had not been updated to reflect this information. Management stated this was a trial and was being communicated through handover and staff stated they attend in the morning consistent with the trial but sometimes need extra staff due to the consumer’s changed behaviours.
* Consumer L’s care planning documentation relating to life events and profile were blank and did not include the consumer’s heritage.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings. The following evidence was considered relevant to my finding;

* Asserts the advance health directives are not required as part of consumers entering a service and provided an internal palliative framework document confirming processes to discuss advanced care planning and end of life wishes. This document showed the service has processes to discuss advanced care planning based on a set trajectory.
* Consumer K has been assessed by allied health staff to require 3 staff for personal hygiene and the consumer’s care plan has since been reviewed with the service’s manager and representative.
* Acknowledged Consumer L’s life event assessment was not completed and has since been completed.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was able to demonstrate 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.

In coming to my finding, I have considered the intent of the Requirement and specifically, if the consumer wishes*.* I have considered the consistent feedback provide by management and the palliative care framework documentation supporting my view that staff were following internal processes and undertaking advanced care planning and end of life planning conversations. I have also considered evidence in Standard 3 Requirement (3)(c) which stated for three consumers end of life wishes were recorded which indicates relevant assessment and planning being undertaken in relation to end of life and advanced care planning to support my finding.

In relation to consumer K, I find whilst the consumer’s care planning and assessment documentation did not document their preferences for personal hygiene attendance, I have considered this as ineffective review as staff were trialling the strategy for approximately a month without an evaluation of the strategy which has been considered in my finding for Requirement (3)(e) in this Standard.

In relation to Consumer L, I find whilst Consumer L’s life event assessment was not completed, I have considered that no further evidence was presented by neither the Assessment Team nor Approved Provider that care and services were impacted because of the assessment not being completed.

Based on the information summarised above, I find Requirement (3)(b) compliant in Standard 2 Ongoing assessment and planning with consumers.

## Requirement (3)(e)

The Assessment Team recommended Requirement (3)(e) in this Standard not met. The service was not able to demonstrate care and services were reviewed for two consumers following return from hospital and for one consumer in relation to deteriorating vision. The following evidence was considered relevant to my finding;

* Consumer K returned from hospital and their care plan was not updated to reflect recommendations made to manage the consumer’s swallowing risk with care staff not being aware of strategies recommended.
* Consumer F returned to the service with progress notes documenting a strategy to manage the consumer’s oxygen which was not updated and was addressed by management following feedback.
* Consumer H had a decline in their vision and staff were managing the consumer’s high-risk medications, however the consumer’s care planning documentation has not been updated to reflect the consumer is no longer self-administering their medication.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Acknowledged, whilst Consumer K’s care plan was not reviewed immediately following return from hospital, management stated the representative assists with meals and has always used the strategy recommended by the hospital discharge summary.
* Acknowledge Consumer F’s oxygen therapy care plan was not immediately updated with recommendations made, however, provided progress notes stating the consumer’s oxygen was being monitored.
* Acknowledged Consumer H’s self-medication assessment was not updated however asserted relevant staff were aware of the decline and the consumer’s medication was charted.
* Initiated a return from hospital checklist form which is currently being trialled and is included in the plan for continuous improvement.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate care and services were reviewed regularly for effectiveness, specifically for Consumers K and F following return from hospital, Consumer H following a decline impacting their medication management and Consumer L who did not have a relevant life history assessment completed.

I find Consumer K’s care and services were not reviewed following return from hospital to support effective management of the consumer’s swallowing risk. Whilst I recognise the representative was providing care and services potentially consistent with the recommendations in the discharge summary, I have placed weight on the evidence where care staff were not aware of strategies recommended and care planning documentation which was not updated to support effective management in the event the representative being not available. I have also considered evidence documented in Standard 2 Requirement (3)(b) as ineffective review as the staff were trialling a strategy for approximately one month without an evaluation of the strategy for effectiveness, being indicative of ineffective review.

I find Consumer F’s care and services were not effectively reviewed with relevant assessment and planning completed and specifically oxygen therapy directives updated following return from hospital. Whilst I have considered the additional evidence provided including the two days of progress notes showing monitoring of the consumer’s oxygen, I have considered and placed weight on the importance on having an accurate oxygen therapy directive and management plan which was not updated following the consumer’s return from hospital or a planned approach to monitoring the consumer’s oxygen therapy developed on return.

I find in relation to Consumer H, care and services were not effectively reviewed with relevant assessments updated to inform staff specifically in relation to safe medication management.

I have also considered evidence documented in Requirement (3)(b) in this Standard in relation to ineffective review for Consumer L who did not have their life events and profile assessment completed.

Based on the information summarised above, I find Requirement (3)(e) non-compliant in Standard 2 Ongoing assessment and planning with consumers.

**In relation to all other Requirements**, assessment and planning includes the consumer and if the consumer wishes their representatives, and other service providers. Consumers and representatives expressed satisfaction assessment and planning occurred in partnership. Staff described how other service providers are engaged to support assessment and planning including in relation to wound care and palliative care.

Outcomes of assessment and planning are effectively communicated to consumers and overall documented in the care and services plan. Staff were able to describe how they can access care plans. Consumers and representatives stated they were satisfied outcomes of assessment and planning are effectively communicated although 2 consumer representatives stated they have not seen a care plan.

Based on the information summaries above, I find Requirements (3)(c) and (3)(d) 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. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I have assessed the Quality Standard as non-compliant as I am satisfied Requirements (3)(a), (3)(b) and (3)(f) are non-compliant.

The service was found non-compliant with Requirements (3)(a) and (3)(b) following a Site Audit conducted from 19 April 2021 to 21 April 2021 where it was found the service was unable to demonstrate each consumer gets safe and effective clinical care and personal care in relation to restrictive practices including physical restraint such as when using low-low beds, use of chemical restraint as a last resort and for one consumer who was not regularly provided personal care due to staff not being able to manage the consumer’s changed behaviours. In addition, the service did not demonstrate effective management of high-impact and high-prevalence risks in relation to consumers experiencing changed behaviours, falls and pain. The Assessment Team’s report did not include improvements implemented in response to the non-compliance.

## Requirement (3)(a)

The Assessment Team recommended Requirement (3)(a) in this Standard not met as the service was not able to demonstrate each consumer gets safe and effective personal or clinical care in relation to medication management, diabetes management and oxygen therapy management. The following evidence was considered relevant to my finding;

* The representative for Consumer H was not satisfied with safe medication management as once the consumer was provided the incorrect dose of one medication and on another occasion the consumer was provided wrong medications. The representative was not informed of one of the two incidents and was waiting for a response. An incident form was also not completed. In addition, Consumer H had an increase in monitoring requirements following a decline in relation to their diagnosed condition being diabetes, however monitoring was commenced three days later.
* Consumer C’s representative was not satisfied the consumer’s medications were being administered effectively with one type of medication administered few hours after the initial round of medications. Documentation showed a large number of medication errors which management said was due to the electronic time frame which has since been increased.
* A copy of the medication administration record showed Consumer M did not have their medication administered for a five-day period with management stating they are investigating the incident.
* Consumer F, returned from hospital in the evening of day two of the Site Audit with progress notes showing recommendations for two varying oxygen saturation levels. However, since returning to the service the consumer had one set of oxygen saturation levels completed and the consumer said to the Assessment Team they were short of breath and would not ring the bell as they were not confident anything would happen.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Asserted the medication error referred to in the Assessment Team’s report in relation to Consumer H and incorrect dosage did not occur with records confirming all medications were administered. In relation to the second incident, a near miss had occurred with a follow up email which was provided dated the day of the Site Audit and they had discussed the incident with the consumer as they are the decision maker.
* A continuous improvement was underway in relation to the management of diabetes. The response, acknowledged deficits in monitoring, however noted no adverse outcome for Consumer H and a subsequent review by the dietitian noted stable blood glucose levels. Care conversations have been undertaken and the representative is satisfied with actions taken to address their concerns.
* Care conversations were undertaken in relation to Consumer C and the representative is satisfied with actions taken.
* Acknowledged they were investigating the incident for Consumer M as it was a five-day short course and were seeking clarification from the medical officer. Administration records for a five-day period were provided which showed two administrations were missed, with one documented as no stock and the other as refused. A record from the medical officer was provided dated during the site audit approximately 10 days after the final medication administration record advising no further action regarding the missed medications. In addition, progress notes documenting the consumer was not satisfied regarding not completing the entire course of medications approximately 10 days prior to the Site Audit.
* Acknowledged opportunities for improvement for Consumer F in relation to documentation and specifically the consumer’s oxygen therapy care plan. Whilst evidence of progress notes was provided, the progress notes showed inconsistent monitoring with records approximately once per shift. The progress notes showed a chart was subsequently developed approximately a day after returning to the service with instructions for the monitoring of the consumer’s oxygen saturation to be completed once per shift.
* A continuous improvement was underway in relation to transitioning consumers onto the electronic documentation system prior to the Site Audit and an increase in the medication round time was implemented significantly reducing the incidents.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate effective and best practice tailored care in relation to; Consumer H and diabetes management, and medication management; Consumer F and oxygen therapy management and monitoring, Consumer C, M and T and medication management; Consumers F, N and O and post falls monitoring; and consumer K and behaviour support.

In relation to Consumer H, I find the consumer did not receive best practice and tailored clinical care in relation to their specialised nursing need. Whilst I acknowledge and have considered improvements were underway at the time of the Site Audit, the consumer was not receiving effective clinical care with respect to their specialised nursing need being diabetes for a period of three days consistent with best practice.

In relation to Consumer F, I find the consumer did not receive best practice clinical care following return from hospital and specifically in relation to oxygen therapy management. Whilst the progress notes indicated the consumer’s oxygen saturation levels were being maintained and monitored approximately once per shift, I am not satisfied sufficient monitoring was being undertaken whilst noting on return to the service it was the consumer’s first night without oxygen therapy and with only one saturation reading being undertaken. In relation to medication management, I find the consumer did not receive effective medication management. I have relied on the evidence which indicates an incident form was not completed at the time of the incident being the near miss to demonstrate safe, effective, and best practice medication management to support effective follow up.

In relation to Consumer M, I find the consumer did not receive best practice and effective medication management. Whilst, I have considered the service was seeking clarification from the medical officer in relation to the missed medication administrations during the Site Audit, I have noted a response was received approximately 10 days after the last medication administration date, which is inconsistent with best practice medication management. I have relied on the evidence which showed for two of the five administrations the medication was not administered and further guidance was not promptly sought from the medical officer to inform an effective management plan despite the consumer raising their concern regarding not completing the entire short course.

In relation to Consumer C, I accept the service was implementing an improvement in relation to administering medications within an increased time frame. However, the evidence presented showed a large number of medication errors coupled with the representative being dissatisfied with the timing of medication administration.

I have considered information documented in Standard 3 Requirement (3)(b) in relation to Consumers F, N and O and post falls monitoring. I find the service did not undertake post falls monitoring consistent with best practice.

I have considered evidence documented in Standard 7 Requirement (3)(c) where the Assessment Team observed Consumer T to have medications on their table which were not effectively administered with management confirming the observed practice was not consistent with the organisation’s process.

I have considered evidence documented in Standard 3 Requirement (3)(f) indicative of ineffective behaviour support impacting on the delivery of effective personal care. I have noted the evidence from the representative for Consumer K being previously dissatisfied with the provision of personal care for the consumer with the charting demonstrating the consumer was hitting staff when they provided personal care. I acknowledge information included in the Approved Provider’s response that shows the consumer has since the Site Audit been referred to a specialist service with strategies suggested being implemented with an improvement noted.

Based on the information summarised above, I find Requirement (3)(a) non-compliant in Standard 3 Personal care and clinical care.

## Requirement (3)(b)

The Assessment Team recommended Requirement (3)(b) in this Standard not met, as the service was not able to demonstrate effective management of high-impact and high-prevalence risks associated with falls management and post falls monitoring, high-risk medication used in the form of chemical restraint and the management of malnutrition. The following evidence was considered relevant to my finding;

* Consumer H has experienced three falls in the previous two months and developed two pressure injuries. Their representative described how they were on the floor for hours calling out 10 days prior to the Site Audit when they fell and were subsequently transferred to hospital. The consumer stated their sensor mat is often not implemented. A further two falls occurred in the month prior where staff did not complete relevant post fall monitoring. In addition, the consumer subsequently developed two pressure injuries with management stating they were not sure how the pressure injuries occurred.
* Consumer F experienced a fall and reported being on the floor for hours with evidence provided demonstrating insufficient post fall monitoring. Consumers N and O experienced four falls combined and did not have neurological observations completed consistent with internal policies and procedures
* Consumer K has lost significant weight in the previous six months with recommendations made by a dietitian for supplements to be provided. However, whilst the representative stated they purchased the supplements, documentation does not show the provision of the supplements and food intake monitoring charts are inconsistently completed.
* Four consumers who have behaviour support plans did not have alternatives trialled prior to all administrations of chemical restraint medication. For Consumer P, in the month of the Site Audit, four medication administrations were recorded with strategies trialled for two of the four administration, one administration as not being documented, and one as early medication given.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings. The following evidence was considered relevant to my finding;

* For Consumer H, daily rounds are undertaken hourly, and it is unlikely the consumer was on the floor for greater than one hour and acknowledged an improvement plan was underway in relation to falls management. In relation the pressure injuries, acknowledged an incident form was not completed, however stated at the time the consumer was referred to a specialist service with documentation provided showing a wound management plan was commenced.
* Acknowledge improvements were underway in relation to falls management and did not directly respond to deficits in post falls monitoring for Consumers F, N and O.
* Acknowledged Consumer K’s supplement was not charted and felt confident the consumer was receiving the supplement, as the representative supports the consumer with their meals. On review of the consumer’s weight, it was determined the weight recorded six months prior was incorrect and the consumer’s weight has remained stable.
* Reviewed and updated Consumer P’s behaviour support plan to ensure it is person centred, referred the consumer to a medical specialist and implemented a plan for continuous improvement following the Site Audit in relation to dementia care and restraint minimisation.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate effective management of high-impact and high-prevalence risks for; Consumer H and management of the risk of falls and pressure injuries; Consumer K and management of the risk of malnutrition; Consumer P and management of high-risk medications and behaviour support.

In coming to my finding for consumer H, I find the consumer’s high-impact and high-prevalence risk associated with falls was not effectively managed. I have relied on the evidence from the consumer where the strategy to manage the consumer’s risk of falls was not being effectively implemented, being the sensor mat. I have also considered that evidence was not provided to demonstrate the sensor mat was implemented at the time of the fall to ensure appropriate and timely management. Whilst I acknowledge improvements were underway in relation to falls management and post falls monitoring, I have considered these were not implemented at the time of the Site Audit to ensure effective management of the consumer’s risk associated with falls. In relation to risks associated with pressure injury management, I have noted whilst a wound management plan was commenced and a referral completed for specialist input, an incident form was not completed or an effective review undertaken to identify the cause of the pressure injury to support effective management of the consumer’s high-impact risk.

In relation to Consumers F, N and O, I find the service did not undertake post falls monitoring consistent with best practice and I have considered this information in my finding for Requirement (3)(a) in this Standard.

In relation to Consumer K, I find the service did not effectively manage the consumer’s risk of malnutrition. I have considered the strategy recommended by the dietitian, being the supplement, was not effectively monitored to manage the consumer’s risk of malnutrition with food monitoring charts not being effectively monitored, evaluated, and reviewed.

In relation to restrictive practices and specifically Consumer P, I find the service did not manage the consumer’s high-risk medications effectively and specifically ensuring effective alternatives were being trialled prior to medication administration. Whilst I recognise the consumer had a behaviour support plan, this was not individually tailored consistent with best practice and person-centred care at the time of the Site Audit.

Based on the information summarised above, I find Requirement (3)(b) non-compliant in Standard 3 Personal care and clinical care.

## Requirement (3)(f)

The Assessment Team recommended Requirement (3)(f) in this Standard not met, as the service was not able to demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services, specifically in relation to the management of changed behaviours and malnutrition. The following evidence was considered relevant to my finding;

* The representative was concerned Consumer K’s changed behaviours were impacting on staffs’ ability to provide personal care and the service had suggested a referral to a specialist service, however management were unable to find evidence of the referral.
* Consumer P is being administered medication for the management of their changed behaviours with recent increases in the dosage of one of the medications, however management were unable to find evidence of referral to a specialist service.
* Consumer F experienced significant weight loss during the preceding two months and a referral was not able to be located for a dietitian review.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Consumer K was referred to a specialist service one day after the Site Audit with recommendations implemented.
* Consumer P was referred to an internal specialist following the Site Audit in relation to behaviour support.
* Assert nursing staff had identified Consumer F lost weight and a referral was completed prior to the Site Audit, however evidence of the referral was not provided. Evidence showed the consumer was reviewed by the dietitian one day after the Site Audit with a possible cause of weight loss attributed to their medical condition and had regained their weight.
* Meetings have been conducted with clinical staff and there has been a significant reduction in the use of as required medications. In addition, the lifestyle program has been reviewed to better support consumers requiring behaviour support.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate effective referral processes for Consumers K and P in relation to behaviour support and for Consumer F in relation to weight management.

I find, in relation to Consumers K and P, the service was not able to demonstrate timely referrals in relation to behaviour support to support effective management. Consumer K experienced increased changed behaviours impacting on the provision of personal care and Consumer P was prescribed and administered an increased dosage of medication indicating consumers’ behaviour support was not being effectively managed.

I find, in relation to Consumer F, the service was not able to demonstrate timely referrals, whilst the service asserts the consumer’s weight loss was recognised and a referral initiated evidence to support this initial referral was not demonstrated with the consumer being reviewed the day after the Site Audit.

Based on the information summarised above, I find Requirement (3)(f) non-compliant in Standard 3 Personal care and clinical care.

**In relation to all other Requirements**, the needs, goals, and preferences of consumers nearing end of life are recognised and addressed and their dignity preserved. Staff stated and documentation demonstrated consumer’s comfort and dignity is preserved for consumers nearing end of life. Clinical staff described how they maintained one consumer’s pain whilst they were nearing end of life to support their comfort and dignity.

Policies and procedures ensure consumers’ deterioration is recognised and responded to. Consumers and their representatives expressed being satisfied staff responded in a timely manner and documentation demonstrated appropriate interventions being implemented in a timely manner. Staff were able to describe signs and symptoms associated with deterioration and actions to undertake following recognition of deterioration.

Processes ensure 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. Clinical staff were able to describe how they liaise with other service providers. Staff stated they receive the information they need to provide care to consumers. Six consumers and representatives stated staff know the consumers and what care is required.

Standard and transmission-based precautions are employed to prevent and control infections. Policies and procedures promote appropriate antibiotic prescribing. Staff were able to describe how they prevent transmission of infections and antimicrobial stewardship principles. However, the antimicrobial usage register included consumers who did not have an infection incident form consistent with organisational procedures.

Based on the information summaries above, I find Requirements (3)(c), (3)(d), (3)(e) and (3)(g) compliant in Standard 3 Personal care and clinical care.

# 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)(c) | 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 |

Finding

The service was found non-compliant with Requirements (3)(b) and (3)(c) following a Site Audit conducted from 19 April 2021 to 21 April 2021 where it was found the service was unable to demonstrate effective emotional and psychological support for two consumers following incidents and limited provision of chaplaincy services. In addition, for consumers in the memory support unit, services and supports for daily living did not support them to participate in their community and do things of interest. The Assessment Team’s report did not include improvements implemented in response to the non-compliance

Consumers and representatives were satisfied they were receiving safe and effective services and supports for daily living that meet their needs, goals and preferences and optimises their independence, well-being, and quality of life. Lifestyle staff described how consumer profiles are commenced on entry to support consumer independence, health, well-being, and quality of life. One consumer described how their independence is maintained by undertaking regular exercise with an allied health worker.

Consumer’s emotional, spiritual, and psychological wellbeing is promoted, and staff described how consumers are assessed and referred for appropriate emotional and psychological support when required. Documentation showed all consumers have a documented personal profile which identifies consumers who attend religious and spiritual services. Registers identify consumers who are at risk of isolation and strategies to support their emotional well-being.

Services and supports for daily living assist each consumer in maintaining relationships and participating in the community and to do things of interest. The weekly group activity program has a range of activities for consumers. In addition, individual activities are offered for consumers to support their well-being. Lifestyle staff described how the activity program is reviewed in response to feedback and consumers described the activities they participate in including singalongs, church services and activities in the community such as music rehearsals.

A variety of methods are used to effectively communicate consumer needs and preferences. Staff were able to describe how systems and processes including handover, staff meetings and the electronic care system ensure effective communication. Care plans demonstrated timely and appropriate referrals to individuals or other service providers including mental health professionals and allied health workers.

Meals are varied and of suitable quality and quantity. Most Consumers expressed satisfaction with meals being provided and observations made during lunch time meal services showed a relaxed environment. Food focus groups are undertaken monthly, and consumers have input into the menu.

Equipment provided is safe, clean and well maintained. Lifestyle equipment and mobility aids were observed to be clean and well maintained. Staff described having access to relevant equipment and maintenance reporting processes.

Based on the information summarised above, I find the service compliant with all Requirements in Standard 4 Services and supports for daily living.

# 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 is welcoming and supports consumers free movement with directional signage and comfortable spaces. Lighting, posters and artwork supports consumers’ independence and belonging, and consumers and representatives said they felt at home in the service. Staff interviewed said the service environment is monitored through scheduled maintenance, cleaning, audits, surveys, and consumer feedback.

The environment including furniture and fittings were observed to be clean and well maintained. Consumers were observed to be moving freely and staff were observed to be cleaning consumer rooms and communal areas. Documentation demonstrated regular preventative and reactive maintenance. Consumers and representatives said they felt safe at the service and the environment is clean and well maintained. Staff confirmed shared equipment is cleaned after use and common fixtures including handrails and door handles are regularly cleaned. The maintenance manager confirmed monitoring maintenance requests daily which are prioritised based on urgency.

Based on the information summarised above, I find the service compliant with all Requirements in Standard 5 Organisation’s service environment.

# 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

I have assessed the Quality Standard as non-compliant as I am satisfied Requirement (3)(c) is non-compliant.

The Assessment Team recommended Requirement (3)(c) in this Standard not met as the service was not able to demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. The following was considered relevant to my finding;

* Consumer B stated their initial complaint had not been addressed and their concerns not fully resolved despite the documentation showing the complaint was closed approximately three months prior to the Site Audit.
* The representative of Consumer Q described providing verbal feedback on two issues however only one issue was addressed. An incident form was not completed, and open disclosure undertaken.
* Consumer F stated they made complaints about another consumer coming into their room and not having access to care documentation. The representative was not fully informed following the incident.
* The representative of Consumer R raised feedback about the provision of personal care which has not been addressed.
* A staff member working with Consumer S stated they complain when their needs aren’t met with complaints documented in behaviour charts and communicated via email.
* An incident form for Consumer H which was brief. Staff advised open disclosure was being undertaken however the incident report did not document the discussion or evidence open disclosure being undertaken.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Asserts they were not aware Consumer B’s concern was not addressed and provided evidence of the feedback documentation documenting the closure of the feedback and stated an investigation was undertaken and relevant communication to inform staff of the consumer’s preferences had been completed with the consumer confirming the matter had been resolved.
* In relation to Consumer Q, acknowledged feedback was received on both issues and management undertook an investigation and had liaised with the consumer as opposed to the representative and the feedback case remains open.
* In relation to Consumer F, the response stated they will follow up with the representative in relation to providing further care planning documentation and acknowledged improvements in open disclosure underway prior to the Site Audit
* Provided evidence of feedback for Consumer R which showed the complaint was closed.
* Provided records of behaviour charts for Consumer S showing the majority of issues raised as being changed behaviours however, I noted feedback was being provided in relation to missing items which was not being addressed whilst the response asserts, they were episodes of changed behaviours.
* In relation to Consumer H, stated further examples were provided to the Assessment Team demonstrating improvements in practice.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate where all feedback was provided including in relation to complaints that appropriate action was taken and open disclosure process were undertaken specifically for Consumers Q, F, S and H.

In relation to Consumer B, I have considered the response and feedback documentation provided indicating that appropriate action was undertaken in response to feedback and whilst the consumer subsequently expressed dissatisfaction, the evidence indicates the consumer’s concern had been initially addressed.

In relation to Consumer Q, I have considered the representative provided verbal feedback on a concern raised by the consumer to nursing staff, and whilst an investigation was completed the outcome was not effectively communicated for one of the two issues raised.

In relation to Consumer F, I have considered the evidence which demonstrated the consumer’s feedback was being addressed however open disclosure was not being practiced with the service confirming planned improvements.

In relation to Consumer S, I find the behaviour charts were showing feedback being provided such as in relation to missing items with the charts indicating the consumer’s issues were not being addressed.

In relation to Consumer H, I find relevant open disclosure was not demonstrated whilst the service acknowledges improvements being underway.

Whilst, I have also considered evidence of feedback being actioned documented in Requirement (3)(d) in this Standard from the Assessment Team’s report, I have placed weight on the evidence presented in this Requirement for Consumers Q, F, S and H.

Based on the information summarised above, I find Requirement (3)(c) non-compliant in Standard 6 Feedback and complaints.

**In relation to all other Requirements**, Consumers stated whilst they did not recall being provided information regarding providing feedback, they felt comfortable to raise feedback. Consumers and their representatives said they are invited to monthly meetings and have an opportunity to raise concerns or provide feedback. Observations at the service showed feedback forms are available throughout the service.

Consumers are made aware of advocacy services as well as language services and other methods of raising and resolving complaints. Documentation viewed showed information is supplied to new consumers and observations showed pamphlets were available near the reception desk regarding advocacy services. The consumer and their representative confirmed being aware of advocacy services available.

Feedback is recorded and monitored to improve the quality of care and services. Management described how staff are responsible for the collation and uploading of feedback and complaints on a daily basis to support the monitoring of feedback. Documentation viewed showed the service has processes to monitor feedback. Recent improvements to improve the quality of care and service following feedback included using the outdoor area during warm weather for a barbeque.

Based on the information summaries above, I find Requirements (3)(a), (3)(b) and (3)(d) 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. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

I have assessed the Quality Standard as non-compliant as I am satisfied Requirement (3)(c) is non-compliant.

The service was found non-compliant with Requirements (3)(a) and (3)(b) following a Site Audit conducted from 19 April 2021 to 21 April 2021 where it was found the service was unable to demonstrate the workforce was able to deliver safe and quality care and services specifically for consumers in the memory support in relation to supporting them with their mobility, changed behaviours and meal services. In addition, whilst most staff interactions with consumers were observed to be kind, caring and respectful, lunchtime meal services were observed to be rushed with limited engagement and one consumer was not satisfied following being involved in an incident. The Assessment Team’s report did not include improvements implemented in response to the non-compliance.

## Requirement (7)(c)

The Assessment Team recommended Requirement (3)(c) in this Standard not met as the service was not able to demonstrate staff competently performed their roles or follow internal policies and procedures impacting on the provision of care and services. The following was considered relevant to my finding;

* Despite staff being provided training on feedback and complaints staff were not following relevant policies and procedures and provided two examples.
* Staff were not effectively undertaking appropriate assessment and care planning for Consumers K and F following return from hospital and for Consumer H following changes.
* Staff were not able to demonstrate they were competent in the management of high-impact and high-prevalence risks and specifically risk of malnutrition for Consumer K and effective management of Consumer C’s risk associated with meals and an adverse event.
* The Assessment Team observed Consumer T to have 2 tablets on the table which management confirmed was not consistent with their process. Two representatives stated they were not confident medications were being managed safely and an example was provided involving Consumer H.
* Staff were not effectively recording alternatives trialled for four consumers prior to the administering of as required medications used in the form of chemical restraint.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Asserted they disagree with the examples provided being indicative of staff not being competent in relation to feedback.
* Acknowledged clinical documentation required improvement which was identified prior to the Site Audit.
* The high-impact and high-prevalence risk described for Consumer C was a near miss and high-impact risk for Consumer K was considered in Standard 3 Requirement (3)(b) with the consumer’s risk of malnutrition effectively managed.
* In relation to restrictive practices and chemical restraint the service has implemented a range of improvements and commenced a restraint minimisation project and a medication evaluation improvement project.

I acknowledge the Approved Provider’s response and the additional information provided. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service was not able to demonstrate the workforce is competent and have the knowledge to effectively perform their roles. This includes in relation to open disclosure and actioning feedback, assessment and planning and delivering personal and clinical care in relation to medication management including high-risk medications, behaviour support, falls management, specialised nursing needs including oxygen therapy and diabetes management, incident reporting and timely referrals for consumers in relation to personal and clinical care.

I have considered the evidence in relation to Standard 6 Requirement (3)(c) indicative of deficits in staff competence in relation actioning feedback and staff practicing open disclosure. I have relied on the evidence which showed for Consumers Q, F, S and H appropriate action and/or open disclosure was not undertaken.

In relation to the management of high-impact and high-prevalence risks, I have considered deficits documented in Standard 3 Requirement (3)(b) specifically in relation to the management of risks associated with falls, wounds, malnutrition, and high-risk medications used in the form of chemical restraint.

Whilst I acknowledge the service has commenced undertaking improvements prior to the site which included in relation to falls management and incident reporting and further training being scheduled in relation to restrictive practices and behaviour support. I find the deficits identified in Standard 2 and 3 as evidence to support my finding of the workforce not being competent and having the knowledge to effectively perform their roles.

Based on the information summarised above, I find Requirement (3)(c) non-compliant in Standard 7 Human resources.

**In relation to all other Requirements**, most consumers and representatives said they were satisfied with the staffing levels at the service. Staff said there are enough staff in each area of the service. Management said the rosters are reviewed regularly to ensure staffing levels meet the needs of consumers. Nine staff said the permanent staffing levels have improved at the service. A review of the roster showed 14 permanent vacant shifts each fortnight with 5 of those shifts being permanently filled in the near future.

Most consumers and representatives said whilst there were concerns that some staff were not knowledgeable of their needs and preferences, staff are kind and caring when providing care and services. One consumer described an example of staff not being aware of their preferences which was discussed with management and the care plan was updated during the Site Audit. Staff were able to describe examples of how they practice day to day respectful care and were observed throughout the Site Audit interacting with consumers and their families in a kind and respectful manner.

Scheduled training is undertaken annually and as part of onboarding for staff. Staff new to the service complete buddy shifts and have regular reviews of performance. Further education and training are provided if the service has identified deficits in work practice. Agency staff are provided an orientation and checklist to ensure they understand their roles and responsibilities, however one labour hire worker said they were not provided an orientation. Documentation viewed showed regular training being provided.

Performance review and performance management processes are in place that includes performance appraisals for new staff following their probationary period and then ongoing for all staff annually. Six of 8 staff interviewed said they had a recent performance assessment with management to follow up with the remaining two staff. Documentation viewed showed staff being provided performance counselling following incidents consistent with internal policies and procedures.

Based on the information summaries above, I find Requirements (3)(a), (3)(b), (3)(d) and (3)(e) compliant in Standard 7 Human resources.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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

I have assessed the Quality Standard as non-compliant as I am satisfied Requirements (3)(d) and (3)(e) are non-compliant.

The service was found non-compliant with Requirements (3)(c) and (3)(d) following a Site Audit conducted from 19 April 2021 to 21 April 2021 where it was found the service was unable to demonstrate effective organisation governance systems relating to regulatory compliance with one incident of mandatory reporting not being completed and reported within the required time frames. In addition, the service did not demonstrate for some consumers effective identification and management of high-impact and high-prevalence risks and effective response for one consumer following an alleged incident of abuse. The Assessment Team’s report did not include improvements implemented in response to the non-compliance.

## Requirement (3)(d)

The Assessment Team recommended Requirement (3)(d) in Standard 8 not met, as the service was not able to demonstrate effective risk management systems and practices, in relation to supporting consumers to live the best life they can and managing high-impact or high-prevalence risks associated with the care of consumers. The following evidence was considered relevant to my finding;

* Consumer J chooses to have their door locked but did not have a risk assessment. Consumer F had a risk assessment completed which was for a gate and not for a door. Following feedback, 11 consumers were identified having their doors locked at night.
* Monthly clinical indicator reports identified ineffective falls management with planned education. The following month the clinical indicator report documents ongoing issues in relation to falls management and a staff member undergoing performance management in relation to not following falls management processes. The Assessment Team viewed 6 consumer files which showed staff continue to not follow policies and procedures in relation to falls and monitoring.

The Approved Provider’s response indicates they disagree with the Assessment Team’s findings and provided additional information and commentary. The following evidence was considered relevant to my finding;

* Assert the two sub-requirements identifying and responding to abuse and neglect of consumers and managing and preventing incidents including the use of the incident management system have not been addressed in the report.
* A plan for continuous improvement in relation to privacy locks and dignity or risk was provided.
* An executive presentation was provided outlining a range of information including risk management, incident reporting, clinical dashboard and clinical focus areas.

Based on the Assessment Team’s report and the Approved Provider’s Response, I find the service was unable to demonstrate effective risk management systems and practices in relation to managing high-impact and high-prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management system. However, I find the service was able to demonstrate effective processes to support consumers to live the best life they can and processes to support identifying and responding to abuse and neglect of consumers.

In relation to risk management systems and practices and managing and preventing incidents, including the use of an incident management system, I find the service was unable to demonstrate this aspect of the Requirement. Whilst I acknowledge the Assessment Team’s report did not directly address the sub requirement, I have considered the evidence documented in the Assessment Team’s report and relied on the evidence demonstrating staff are not always completing incident forms to support the use of the incident management system. I have considered evidence documented in the Assessment Team’s report including a near miss medication incident which occurred where staff did not complete an incident form for Consumer H. In addition, for Consumer H staff did not complete an incident form following the identification of pressure injuries. Moreover, staff did not complete an incident form following an incident involving Consumer Q and another consumer. Finally, I have considered evidence documented in Requirement (3)(e) in this Standard where incident forms in relation to infections were not being completed consistent with the organisations policies and procedures.

In relation to risk management systems and practices in managing high-impact or high-prevalence risks associated with the care of consumers, I find the service was unable to demonstrate this aspect of the Requirement. Whilst I acknowledge the service has a monthly clinical indicator report which contains analysis of incident data, the service did not demonstrate individual high-impact and high-prevalence risks were being effectively addressed. Additionally, with staff not always reporting incidents into the incident management system, this impacts on the efficacy of identifying and managing individual consumers’ high-impact and high-prevalence risk. I have considered deficits in Standard 3 Requirement (3)(b) and in the management of consumers’ individual risks associated with the management of falls, high-risk medications and risk malnutrition. I have also considered whilst a falls improvement plan was implemented, and the organisation recognised falls management was not being effectively managed the organisation did not ensure high-impact risks associated with falls were effectively managed.

In relation to risk management systems and practices to support consumers to live the best life they can, I find the service was able to demonstrate this aspect of the Requirement. I acknowledge the response which indicated the Assessment Team’s report did not respond directly to this sub-requirement. I have however, considered evidence documented in the Assessment Team’s report specifically Standard 1 Requirement (3)(d) with evidence demonstrating staff practices to support consumers in undertaking activities involving elements of risk. Whilst, I have considered the evidence showing that 11 consumers were identified during the Site Audit to be locking their door and not having relevant risk assessments and development of supports, I have considered this deficit in Standard 2 Requirement (3)(a) as the deficit related to assessment in the context of risk.

In relation to risk management systems and practices to support identifying and responding to abuse and neglect of consumers, I find the service was able to demonstrate this aspect of the Requirement. I acknowledge the response which indicated the Assessment Team’s report did not respond directly to this sub-requirement. I have however, considered evidence documented in the Assessment Team’s report specifically in Standard 7 Requirement (3)(d) where staff stated they were aware of their responsibilities in relation to the Serious Incident Response Scheme (SIRS) and evidence documented in Standard 3 Requirement (3)(b) where management undertook a SIRS report after being made aware of an incident during the Site Audit which supports my finding.

Based on the information summarised above, I find Requirement (3)(d) non-compliant in Standard 8 Organisational governance.

## Requirement (3)(e)

The Assessment Team recommended Requirement (3)(e) in Standard 8 as met as the service was able to demonstrate a clinical governance framework, a range of policies and procedures and staff demonstrated an understanding of antimicrobial stewardship, minimising restraint and some staff were able to describe the organisation’s approach to open disclosure. The following evidence was considered relevant to my finding;

* In relation to minimising the use of restraint, the service maintains a record of consumers who are receiving psychotropic medication and all consumers have a behaviour support plan which is reviewed three monthly. However, for Consumer P four doses of as required medication were provided on separate days with staff either not documenting alternatives trialled or documenting generic strategies.
* In relation to Antimicrobial stewardship, the service has policies and procedures to support staff practices with staff being able to describe antimicrobial stewardship principles. Whilst incident forms were not always completed documentation viewed showed consumers were receiving short duration medications consistent with best practice.
* In relation to open disclosure, policies and procedures guide staff practice, however documentation viewed demonstrated staff were not consistently following open disclosure principles documented in standard 6 Requirement (3)(c).

The Approved Provider did not directly respond to this Requirement.

Based on the Assessment Team’s report, I have come to a different view and find the service was not able to demonstrate effective clinical governance to support the assessment and delivery of effective personal care and clinical care, minimisation of the use of chemical restraint and open disclosure.

In coming to my finding, whilst I acknowledge the service has a range of policies and procedures and monthly clinical indicator reporting, I have considered the integral role of clinical governance in the context of deficits identified by the Assessment Team in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care.

In relation to antimicrobial stewardship, whilst incident forms were not always completed consistent with organisational policies and procedures, I find the service was able to demonstrate this aspect of the Requirement.

In relation to minimising the use of restraint, I find the service does not have effective governance processes. I have considered the evidence specifically in relation to Consumer P and whilst consumers had behaviour support plans, the strategies being trialled were either generic or not documented impacting on effective behaviour support and restraint minimisation within the service.

In relation to open disclosure, I find the service does not have effective governance processes to support and ensure open disclosure is consistently used in response to incidents. In coming to my finding, whilst there are policies and procedures, I have considered staff are not consistently following open disclosure principles in response to clinical incidents as documented in Standard 6 Requirement (3)(c). In addition, I have considered deficits in the incident management system with incident forms not always being completed impacting on staffs’ ability to undertake open disclosure with consumers and representatives.

Based on the information summarised above, I find Requirement (3)(e) non-compliant in Standard 8 Organisational governance.

**In relation to all other Requirements**, the service engages with consumers and representatives in the development, delivery and evaluation of care and services through a range of mechanisms including consumer and representative meetings, food focus group, visitor comments, surveys and care planning meetings. Three consumers described how they attend the consumer and representative meeting and use this forum to raise feedback. Examples were provided of feedback being reviewed to improve the quality of care and services.

The organisation has a range of policies and procedures and sub-committees with a range of reports undertaken monthly and quarterly to ensure safe, accountable, inclusive, and quality care and services. The organisations’ mission and values statement are recorded in the consumer and staff handbook and displayed at the service and six consumers and representative said they believed the service to be well run.

Effective organisation wide governance systems support information management, continuous improvement, financial governance, workforce governance and regulatory compliance. The organisation has an electronic client management system to support information system. Continuous improvements are undertaken informed from a range of monitoring processes. Feedback is monitored and reviewed to identify opportunities for improvement. Management were able to describe processes to support financial expenditure to support them in their duties. Regulatory and legislative changes are received from various sources and implemented. Processes ensure staff are recruited and provided training consistent with organisational values to support workforce governance.

Based on the information summaries above, I find Requirements (3)(a), (3)(b) and (3)(c) compliant in Standard 8 Organisational governance.

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)