Performance

Report

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| Name of service: | Uniting Westmead |
| Service address: | 1 Caroline Street WESTMEAD NSW 2145 |
| Commission ID: | 2461 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Site Audit |
| Activity date: | 17 October 2022 to 21 October 2022 |
| Performance report date: | 15 December 2022 |

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

**This performance report**

This performance report for Uniting Westmead (**the service**) has been prepared by G. Hope-Simpson 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.
* the provider’s response to the assessment team’s report received 1 December 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

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

* **Requirement 1(3)(a):** The provider ensures staff use best practice behaviour support strategies to support consumers living with dementia. The provider ensures restrictive practices are used in full compliance with all legal requirements. The service ensures staff deliver care and services in a manner that protects consumer dignity. The service ensures consumer’s religious, cultural and linguistic needs are identified and used to inform care and services.
* **Requirement 1(3)(b):** The provider ensures accredited interpreters are used and linguistically diverse consumers are offered regular opportunity to express themselves independently. The provider ensures translated materials provided and each consumer’s identity, values and personal history are used to inform care and services.
* **Requirement 1(3)(c):** The provider ensures consumers are supported to make and express decisions about their care and services, and that representatives are supported to exercise their decision-making powers as appropriate. The provider ensures consumers are supported to freely move about and socialise in the service environment.
* **Requirement 1(3)(d):** The provider ensure consumers are supported to take safely take risks they want to take and to make informed risk-taking decisions. The provider ensures risk discussions and decisions are documented, appropriate risk mitigation strategies are identified and consistently implemented. The provider ensures consumers who are environmentally restrained have been assessed as requiring the restraint and all other legal requirements are met.
* **Requirement 1(3)(e):** The provider ensures information about meals and activities are provided to consumers and representatives in a timely manner, to support decision-making. The provider ensures information is in adapted formats, to support consumers with sensory or other communication barriers.
* **Requirement 1(3)(f):** The provider ensures consumers’ personal privacy is respected and protected, staff knock on doors and seek permission to enter. The provider ensures consumer personal information is handled in a way that protects confidentiality. The provider ensures all staff are provided with and attend relevant training in consumer privacy and information handling.
* **Requirement 2(3)(a):** The provider ensures assessment and planning, including consideration of risks relating to hygiene, falls, weight loss, pressure injuries, responsive behaviours, and restrictive practices, is used to inform care and services delivered. The provider ensures validated assessment tools are consistently used, in line with best practice.
* **Requirement 2(3)(b):** The provider ensures assessment and planning identifies and addresses consumers’ current needs, goals and preferences, and consumers with end of life and advanced care plans are clearly identifiable in care plans. The provider ensures all care planning documentation, included documents used in handovers, is internally consistent, accurate and reflect the current assessed needs of each consumer.
* **Requirement 2(3)(c):** The service ensures consumers and representatives have genuine and ongoing partnership in assessment and planning processes and are provided with information about the consumer’s condition and any other relevant information, in a timely manner. The service ensures staff are supported to understand the role and purpose of public guardians and public trustees. The service ensures necessary referrals are made and care and services are informed by recommendations and input from other services, organisations and individuals.
* **Requirement 2(3)(d):** The provider communicates outcomes of assessment and planning to consumers and documents them in care and services plans that are current, accurate and available to consumers and at the point of service delivery. The provider will ensure information management systems are in place which support this outcome staff are supported with adequate time and Electronic Care Management System access points to complete documentation.
* **Requirement 2(3)(e):** The provider ensures care and services are regularly reviewed for effectiveness, care plans are updated on a routine basis and when consumer needs or circumstances change or incidents occur.
* **Requirement 3(3)(a):** The service ensures enough care staff are deployed to provide effective personal care to each consumer. Staff are supported to acquire competence relevant to their scope of practice and monitored to ensure duties assigned reflect appropriate scope. Further staff training is provided in all areas listed in the Continuous Improvement Plan, including, but not limited to, personal care, skin care, pressure injury prevention, wound monitoring and charting, restrictive practices requirements, assessment and planning and recognising and reporting deterioration. Staff practice, including agency staff practice, is monitored for alignment with best practice.
* **Requirement 3(3)(b):** The service ensures high impact and high prevalence risks associated with the care of consumers, including in relation to falls, skin integrity, wound care, swallowing, weight loss, behaviour and restrictive practices are effectively managed.
* **Requirement 3(3)(c):** The provider ensures consumers who are palliative are identified, their end of life care needs, goals and preferences are recognised and addressed. The provider ensures their comfort is maximised and pain and other needs are re-assessed by relevant professionals, to inform changes in care and service delivery.
* **Requirement 3(3)(d):** The provider ensures staff operate within their scope of practice and are supported to recognise and respond to changes in consumer condition, particularly in relation to skin integrity chances. Changes in consumer behaviour are recognised and investigated. Regular clinical oversight and monitoring of staff practice is implemented and maintained.
* **Requirement 3(3)(e):** The service ensures high impact and high prevalence risks associated with the care of consumers, including in relation to falls, skin integrity, wound care and weight loss, are effectively managed.
* **Requirement 3(3)(f):** The service ensures referrals to relevant professionals are made in a timely manner.
* **Requirement 4(3)(f):** The service ensures meals are served of good quality and consumers’ dietary preferences and requirements are met.
* **Requirement 5(3)(b):** The service ensures consumers can move freely inside and outside the service, that consumers are provided with swipe passes to promote freedom of movement and access to balconies. The service ensures all areas of the service are cleaned to sufficient standard and adequate number and mix of staff are employed to achieve this. The provider ensures the service is suitably maintained.
* **Requirement 6(3)(b):** The provider ensures consumers are made aware of and are provided access to advocates, accredited interpreters and other means of raising concerns, with translated and/or multilingual information about these services and avenues provided to consumers.
* **Requirement 6(3)(c):** The provider ensures action is consistently taken in response to complaints and open disclosure practiced when things go wrong. The provider ensures an effective complaints and feedback system is implemented. The provider ensures staff are trained in complaints handling and open disclosure.
* **Requirement 6 (3)(d):** The provider ensures complaints and feedback are documented, opportunities for improvement identified and improvement actions implemented.
* **Requirement 7(3)(a):** The provider ensures the number and mix of staff deployed enables the delivery and management of safe and quality care and services, in relation to both personal and clinical care. The provider recruits more care staff and ensures all staff are operating within scope.
* **Requirement 7(3)(b):** The provider ensures staff provide kind, caring and respectful care and services to consumers.
* **Requirement 7(3)(c):** The provider staff are competent and have the required qualifications and knowledge to effectively perform their roles. The provider ensures staff work within their scope of practice and agency staff are appropriately oriented to the service and the consumer cohort.
* **Requirement 7(3)(d):** The provider ensures staff are required to complete training linked to the Quality Standards. The provider ensures staff are supported with adequate time and resources to complete relevant training and that training completion is monitored by the service. The provider reinforces service policy and procedure for staff training and education.
* **Requirement 8(3)(b):** The service ensures the governing body implements improvements specified in the Continuous Improvement Plan (CIP) provided to the Commission, to ensure it promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The governing body ensures appropriate oversight of the service.
* **Requirement 8(3)(c):** The service ensures deficits in organisational governance systems for information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints are rectified, and actions nominated in the CIP provided to the Commission are implemented.
* **Requirement 8(3)(d):** The service ensures there are effective systems in place for managing high impact, high prevalence risks, dignity of risk and incident management and prevention, as well as recognising and responding to abuse and neglect of consumers.
* **Requirement 8(3)(e):** The service ensures there is an effective Clinical Governance Framework in place which encompasses up-to-date and best practice policies relating to open disclosure, antimicrobial stewardship and the minimisation of restrictive practices. The service ensures staff receive education and training on these topics.
* The Approved Provider implements all planned actions to address identified deficiencies and establishes monitoring process to ensure ongoing compliance with the Aged Care Quality Standards.

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

Findings

The Assessment Team recommended all requirements in this Standard were not met.

**Requirement 1(3)(a)**

Regarding Requirement 1(3)(a) the Assessment Team found the service had policies and procedures to ensure staff treated consumers with dignity and respect and valued their diversity. However, care provided did not align with policy. Evidence brought forward included consumers with a religious requirement for female carers waiting excessive periods for care, as female staff were not available. Male staff were observed rostered on to provide care to those consumers during the site audit. Most consumers said they experienced very long waits for a response to their call bells and this impacted negatively on their dignity. Call bell data reflected long wait times during a recent sampled period. The Assessment Team observed two named consumers in state of undress, in communal areas of the service. A staff member’s response to concerns about the consumers’ dignity was inadequate. Other consumers were unshaven and appeared dishevelled, with soiled clothing and unwashed hair.

The site audit report also brought forward extensive concerns related to the undignified treatment of four other named consumers.

The first named consumer, who lived with dementia, had care planning documentation that contained contradictory directions for personal hygiene care, feeding support and behaviour support and as a result, staff did not have clear understanding of the care to provide. The consumer’s pain and wound care were mismanaged, and they screamed loudly and experienced pain and agitation when the wound was attended, impacting their dignity.

A second consumer living with dementia was observed wearing soiled clothing and appeared unkept. Documentation reflected deficits in their hygiene care. The consumer displayed frequent agitation, wandering, exit-seeking behaviours, inappropriate public behaviours and refusal of care, impacting their dignity. However, their behaviour support strategies were not informed by the consumer’s history or identity and care plans had no clear directives for staff, who did not understand the consumer’s personal and continence care needs. Observations showed ineffective response by staff when the consumer was escalating, resulting in some risk of accidental injury to the consumer. Feedback from the consumer raised concerns about their well-being and continence care.

A third named consumer’s representative said the care provided did not align with their cultural needs and did not protect their dignity. The service failed to provide the consumer with an interpreter, so they could independently raise concerns about the care and services provided to them. The consumer’s religious dietary requirements were not consistently respected, and alternative meal options were not consistently provided. Care staff had complained about lack of variety in the consumer’s diet, but no action was taken.

A fourth named consumer’s requests to leave their room were at times declined by staff, on the basis there were insufficient staff to accompany them. The consumer had no fob to exit through doors, was not able to access balconies to spend time outside and was at times restricted to their room as a result, impacting their dignity. Restrictive practice regulatory requirements had been met. Numerous other consumers were found to be environmentally restrained without relevant legal requirements met.

In their response, dated 1 December 2022, the Approved Provider acknowledged the deficits raised in the Assessment Team report and outlined several immediate actions taken to address the health, wellbeing and dignity concerns identified for specific consumers. The response included supporting evidence of those actions, which included immediate review and re-assessment in core clinical and lifestyle areas, to accurately identify current care and services needs for the named consumers. Care conferences were held and follow-up actions were taken in line with re-assessed needs. The care plans for the entire consumer cohort were also reviewed, to identify and reassess consumers with challenging behaviours and environmental restraints, and to determine accuracy and currency of all care plans. The response also included some further information to contextualise findings, address inaccuracies and included a Continuous Improvement Plan (CIP), which outlined agreed improvement actions the Approved Provider will implement in response to the findings. Planned actions to address deficits in compliance with Requirement 1(3)(a) included an audit to identify all Culturally and Linguistically Diverse (CALD) consumers and update care plans to include cultural and religious preferences, as well as the provision of translated materials and access to interpreter services as planned actions.

The Approved Provider’s response also confirmed the organisation’s executive and board were aware of the audit findings and would be monitoring the service’s response. In addition, the organisation confirmed the appointment of a new and experienced service manager to implement core clinical systems and ensure improved performance of the service and the appointment of a senior quality lead to manage the improvement effort and response to the audit findings. The Approved Provider also undertook to suspend new admissions to the service for at least three months, to focus on implementation of the improvement plan.

While the service has started taking appropriate steps to ensure consumers receive care and services that protect their dignity, steps taken after site audit do not demonstrate compliance. I have given weight to consumer, representative and staff feedback, as well as the Assessment Team’s direct and concerning observations during the site audit. I am satisfied the service failed to ensure staff provided care and services in a way that respected and maintained consumers’ dignity, or which took account of their cultural, religious and linguistic needs and preferences. I am satisfied the service’s care planning and assessment processes did not adequately identify and consistently document the needs of named consumers, and as a result, the consumers’ behaviours and other care needs were mismanaged, which negatively impacted on their dignity. I also find consumers needing female care staff were required to wait for care for extended periods, negatively impacting on their dignity. For these reasons, I am satisfied the service is not compliant with Requirement 1(3)(a).

**Requirement 1 (3)(b)**

The Assessment Team relied on evidence already outlined above in relation to the second and third named consumers, to support the not met recommendation. The report also noted that the service could not confirm the correct spelling of the third CALD consumer’s name and had not taken appropriate action in response to repeated complaints about providing meals that contravened the consumer’s religious requirements. The consumer was noted to repetitively eat the same food, indicating services provided were not culturally safe. Lastly, the report noted consumers who required female care staff for religious reasons were forced to wait extended periods for personal care.

The Approved Provider’s response acknowledged the deficits as outlined above. In addition, the response contained an undertaking to renew the service’s approach to partnership with consumers and representatives through regular case conferences, to ensure care provided aligned with preferences and needs. The response also contained an extensive list of training modules, policies and procedures available to guide staff in provision of culturally safe care; and gave an undertaking to provide additional staff training on Privacy, Dignity, Choice and Respect. The response confirmed the service would facilitate external referrals to, and partner with, experts in diversity and use of interpreters, to better support consumers from CALD backgrounds.

While the response demonstrates the service has identified appropriate actions to improve cultural safety of consumers, steps taken after site audit cannot demonstrate compliance. I note the service had policies and procedures in place to ensure provision of culturally safe care prior to the site audit, however practice did not align with them and deficits in compliance with Requirement 1(3)(b) are linked with deficits in other standards. Therefore, the required changes in practice are numerous, interlinked and will take time to embed. I am satisfied that at the time of site audit, the service did not ensure consumers received culturally safe care in accordance with the Quality Standards, or the service’s own policies and procedures. Consumers did not have their cultural and religious dietary and care requirements met and linguistic diversity was not catered for with the consistent provision of access to accredited interpreters. For these reasons, I find the service is not compliant with Requirement 1(3)(b).

**Requirement 1(3)(c)**

The Assessment Team found consumers were not consistently supported to make decision about their own care, to communicate their decisions or to make connections with others inside the service. The site audit report brought forward evidence from most consumers and representatives, including one consumer’s public guardian, who said they were not involved in decisions about consumer care. The report also identified multiple consumers and representatives had not provided informed consent for use of restrictive practices.

Consumers and representatives said the service environment prevented consumers from making friends inside the service, as access to doors, elevators, balconies and exit from the different wings of the service required a fob, which few consumers had. Consumers relied on staff to grant them any access they required but said staff were frequently too busy to assist them to move about the service. Consumers said they wanted to socialise at the café but could not. Refer to Requirement 5(3)(b) for further information regarding environmental restrictive practices identified during the site audit.

Lastly, consumers said their decisions and choices about how care and services would be delivered were not consistently respected in practice. One consumer reported staff did not take the time to ask their preferences, instead making choices for them.

The Approved Provider’s response acknowledged the deficits above and the CIP contained agreed improvement actions to address the deficits, many of which have been outlined in relation to earlier Requirements. Relevant additional improvement actions included undertakings to ensure staff were aware of consumers’ personal preferences through care plans, huddles and handovers, and to ensure lifestyle programs promoted social opportunities. An undertaking was given to complete care conferences and comprehensive assessments of consumers’ social needs, to inform care and consumer choice. The service also took immediate action to provide consumers with access to their balconies and has commenced planning to safely increase consumer movement throughout the service.

The response demonstrates the service has identified actions to ensure consumers can make decisions about how their care and services are delivered, and to ensure those decisions are respected. I acknowledge these improvement steps being taken, and those planned, to remedy deficits identified in the audit report. However, as they are being taken after site audit, they do not demonstrate compliance with Requirement 1(3)(c). I am satisfied that at the time of site audit, the service was not consistently supporting and upholding consumers’ decisions around who is involved in their care and when and was not supporting consumers to move about the service and make friends. I am also satisfied the service was not ensuring consumers could exercise meaningful choice about how their care and services were delivered, or to express their decisions. For these reasons, I find the service is not compliant with Requirement 1(3)(c).

**Requirement 1(3)(d)**

The Assessment Team found consumers were not supported to take risks which enabled them to live their best lives. Many consumers wanted to be able to leave their respective wings, move about and socialise but were not able to, as previously outlined. Registered staff expressed that it was ‘dangerous’ for consumers to go out independently and said they could only go with staff members; however, the service did not demonstrate risk assessments were completed, to support that determination and there was no evidence risk mitigation strategies were considered as an alternative to restricting consumers. Management of the service did not know how many consumers had a fob to access exits, balconies and the lift, and the service risk register contained consumer risk assessments outdated by 1-2 years, contrary to service policy that reviews be undertaken quarterly. Clinical staff understood the process for assessing risk, however evidence was not provided to show risks were being assessed.

The Approved Provider’s response acknowledged the deficits outlined above and contained planned and implemented actions to address the concerns. The CIP documented efforts made to address freedom of movement concerns for the named consumers, including ordering access fobs for some. The response also noted the service had updated the risk register, to identify consumer’s opting to take some degree of risk, to enhance their quality of life. The response did not contain detail as to the service’s dignity of risk policies or procedures, or how consumers who wanted to take risks would be identified and supported to make informed risk-taking decisions but did note a plan to provide staff with education on dignity of risk.

Having had regard to the information in the site audit report, the provider’s response and the supporting evidence it contained, I find the service did not support consumers to make informed choices about risks they wanted to take, nor did it support them to safely take such risks. I also find it removed choice and restricted movement of many consumers as a result. Consumers were restricted to their rooms on the basis of presumed risk, without supporting assessments to suggest this was necessary. Consumers were not supported to make informed risk-taking decisions and consumers’ independence and self-determination was impacted as a result. For the reasons outlined above, I find the service is not compliant with Requirement 1(3)(d).

**Requirement 1(3)(e)**

The Assessment Team found the service did not provide information about care and lifestyle options, to support consumer/ representative choice and decision-making. Consumers said they did have copies of the activities calendar and did not know where to find one, were not provided copies of resident and relative meeting minutes and did not receive meal menus, nor were they asked what their choices were. Observations showed weekly menus were displayed in kitchenettes but were in small font that was difficult to read. Representatives said they did not receive meeting invitations in a timely manner and were unaware of the activities available for their family members to attend.

In their response, the provider acknowledged the deficits but, in the CIP, provided minimal detail to show how the service would ensure improvements in information provision in the future. An activity calendar for the month following the site audit was provided, but no information about how the calendar would be publicised or promoted to consumers and representatives was included. The response did not address other deficits, such as consumers being unaware of menu options or resident and relative meeting invitations and minutes not being provided.

Having had regard to the evidence in the site audit report, the provider’s response and the supporting evidence included with the response, I find the service did not provide information to consumers and representatives in a timely manner, and as a result, did not enable them to exercise choice. Furthermore, consumers with sensory impairments, such as vision impairments, were not supported with adapted information in appropriate formats. The response did not assure me the service has a clear plan to address the concerns identified during the site audit. For the reasons outlined above, I find the service is not compliant with Requirement 1 (3)(e).

**Requirement 1(3)(f)**

The Assessment Team found consumer privacy was not respected and their personal information was not kept confidential. Consumers said that while staff knocked on their room doors, they did not wait for permission prior to entering. Observations showed a staff member entering a consumer room without knocking, consumer files were stored in unlocked rooms and the computer used by staff when updating care files was in an open location, with consumer information left on screen and easily visible to passers-by. Noticeboards in the nook area also displayed consumer information to passers-by, including sensitive personal medical information.

The Approved Provider’s response acknowledged deficits contained in the site audit report in a general manner but did not directly address the concerns outlined in relation to Requirement 1(3)(f). While the response contained an ‘education plan,’ the document was merely a list of available training modules, policies and procedures available for staff. The CIP did not state how confidential information would be protected and properly stored and did not contain any actions taken or planned to achieve this. While the response contained an undertaking to have staff complete ‘privacy, dignity, choice and respect’ training, it did not specify when this would occur, or which staff would be required to attend.

Having had regard to the evidence in the site audit report, the provider’s response and supporting evidence, I find the service did not ensure consumer privacy was respected and did not protect sensitive consumer information, including medical information. The service displayed confidential information in accessible areas, transgressed consumers’ privacy in their own rooms and did not demonstrate any system to ensure consumer’s privacy remained uncompromised. The response did not assure me the service has a clear plan to address the concerns identified during the site audit. For the reasons outlined above, I find the service is not compliant with Requirement 1(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. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Non-compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

Findings

The Assessment Team recommended all requirements in this Standard were not met.

**Requirement 2(3)(a)**

The service did not demonstrate assessment and planning to inform and support the delivery of safe and effective care services, including consideration of risks. Documentation did not always identify high- impact and high-prevalent risks such as hygiene, falls, pressure injury, continence, restrictive practices, swallowing difficulties, responsive behaviours, pain, and weight loss. Risks associated with consumer’s diagnosis, decline or past health history were not always assessed using validated risk assessment tools and not consistently documented in care plans. Although the service had assessment and care planning policies in place to guide practice, the assessment and care planning process conducted did not align with the policies.

Management reported ongoing issues with incorrect diagnosis of consumers with stage 3 pressure injuries which were instead identified as incontinence acquired dermatitis; therefore care planning was ineffective and consumers were receiving inappropriate care. Consumers and representatives were not always consulted when care needs changed, and reassessment did not always occur in a timely manner. Clinical staff reported they were not always able to reassess or plan care that was safe and best practice.

The Assessment Team identified 4 consumers did not have individualised strategies for effective management of risks which included pressure injuries, pain, weight management, mobility, and behaviours. Relevant deficits in assessment and planning for each named consumer were numerous. Some, but not all relevant deficits are outlined below.

The first named consumer’s care planning documentation was not individualised in accordance with their conditions and recommended strategies for management of their pressure injury, pain, weight, and medication did not meet the consumer’s need. The consumer’s pressure injury was not identified until stage 3 and wound care was not effectively monitored or managed leading to further deterioration and impact on their dignity, as outlined previously in Requirement 1(3)(a).

A consumer was not assessed for correct positioning in their wheelchair to assist with mobility. The consumer experienced pain and sustained skin tears as a result. Skin tears were not investigated or treated as wounds and were mischaracterised as a rash. Wound charting and photography of the wounds did not consistently occur.

As outlined in Requirement 1(3)(a), a consumer’s behaviour support strategies were not tailored, and no clear directives were in place in care plans. Staff were observed managing the consumer’s escalation in an ineffective manner during the site audit, resulting in some risk of accidental injury to the consumer. An obvious falls risk for the consumer had not been identified. The consumer’s falls were not recorded in incident data or identified as a high prevalence risk to monitor. Ongoing hygiene care refusal was not investigated to inform care and services.

Another consumer used bed rails and a lap belt without risk assessments in place. They had not been identified as being subject to physical restraint due to the use of the lap belt. As a result, they had not had relevant assessments and reviews and monitoring, and informed consent were not in place. Obvious risk of choking for the consumer had not been identified and swallowing assessments or speech pathologist review had not been conducted.

In their response, the Approved Provider acknowledged the issues raised in the Site Audit Report and immediately responded to the issues identified to ensure the health, safety and wellbeing of the named consumers. The named consumers now have comprehensive reassessments in place which included review of behaviours support plans, mobility assessments, monitoring of wounds and skin, and assessments from the service dietician have been reflected in care plans. Review of the consumer cohort was completed, to identify other consumers with unidentified risks and the service had commenced review of all consumers’ care plans to ensure they were up to date. The response also contained several other undertakings, including to increase collaboration with a clinical nurse consultant to support the service to improve in dementia, mental health, wound and chronic health condition management. Numerous other undertakings and planned improvements were included in the response and CIP; however space limitations prevent their discussion here.

Having regard to the Site Audit findings and the response, I am satisfied the service is not compliant with Requirement 2(3)(a). Assessment and planning did not consistently inform care and services delivered to consumers, such that staff did not have clear directives for care, particularly in relation to risks. Evidence showed a pattern of staff not completing appropriate risk assessments in response to changes in condition or incidents which signalled increased risk to consumers. For example, clear directions were not in place for monitoring weight loss and behaviours and changes in skin condition were misidentified so care strategies were not in line with appropriate diagnoses. Therefore, I find the service did not consistently ensure assessment and planning, including consideration of risks to consumers’ health and well-being, informed care and service delivery. For these reasons, I find the service is not compliant with Requirement 2(3)(a).

**Requirement 2(3)(b)**

The Assessment Team found assessment and planning did not identify and address consumers’ current needs, goals, and preferences, including advance care planning and end of life planning. The team brought forward detailed information about extensive deficits in assessment and planning, particularly concerning inaccurate or contradictory information in care planning documentation, for 4 named consumers. Review of these consumers’ care plans showed they did not accurately reflect consumers’ current needs, goals and preferences, including in relation to advance care planning, personal hygiene; end of life care; challenging behaviours; skin care, and pain management.

Additionally, one palliative consumer’s advanced care directive contained a directive the consumer was for CPR, however this was reflected inaccurately in handover documentation. The service had received conflicting directions from family members about the consumer’s advanced care, however had not ascertained who the legal representative was, to inform planning. Another consumer’s care planning documentation contained incorrect information about who to contact if the consumer deteriorated, did not identify the consumer was considered palliative by the service and did not include a palliative care plan.

Interviewed staff did not have shared understanding of consumers’ clinical and personal care needs and did not know which consumers were palliating or if a named consumer’s end of life wishes were being followed.

In their response, the Approved Provider acknowledged the issues raised in the Site Audit Report and included a CIP which noted the service had reviewed all consumers’ care plans, to ensure required assessments had been completed and care plans were accurate and up to date. Additionally, the service sent advanced care directive (ACD) forms to relevant consumers and representatives, and overdue and missing assessments had been followed up by clinical staff. Named consumers had their palliative care needs reviewed with their authorised representative.

Having regard to the Site Audit findings and the response, I find the service is non-compliant with Requirement 2(3)(b). Staff could not identify which consumers were for palliative care and assessments and care planning were not consistently completed, to support this. Where completed, care plans were not current at the time of the Site Audit and the care planning documentation was not reflective of the consumers’ current needs in relation to monitoring of skin integrity, pain, behaviours, and other needs. For the reasons outlined above, I am satisfied the service did not ensure assessment and planning identified and addressed current needs goals and preferences, or those relating to advanced care planning and end of life care. Therefore, I find the service is not compliant with Requirement 2(3)(b).

**Requirement 2(3)(c)**

The Assessment Team found the service did not effectively partner with consumers and representatives. Documentation and interviews showed one named consumer’s public guardian had not been made aware when the consumer deteriorated, was diagnosed with a stage 3 pressure injury or had become palliative. One named consumer’s representative reported they were not always informed of medication changes. A significant proportion of consumers were environmentally restricted, without evidence of informed consent provided by representatives or consumers themselves. The Assessment Team also brought forward detailed evidence concerning 4 named consumers, whose clinical risks had not been identified and referred on to relevant specialists, services and allied health professionals, in line with best practice. Details concerning these consumers has been outlined in previous Requirements.

The Approved Provider’s response fully acknowledged the issues raised in the site audit report. The response outlined steps that were taken since the site audit, to ensure the necessary reviews and reassessments were completed and required referrals made for the named consumers. In addition, as outlined previously, the service had reviewed all care plans for currency and need, with consumers requiring referral to allied health and other services identified during the review. The service had communicated and consulted with named consumers’ representatives where possible. The response confirmed that open disclosure had been practiced in relation to a named consumer, and their guardian was consulted and updated about the consumer’s condition. Finally, the CIP reflected a renewed commitment to ensuring ongoing partnership with the consumer and others that the consumer wishes to involve in assessment and planning. A care plan review schedule had been created to this end.

I acknowledge the service has policies and procedures to guide staff practice and ensure genuine partnership with consumers and representatives. I also acknowledge the service has taken action to consult with the representatives identified by the Assessment Team and to ensure relevant other specialists, allied health professionals and services are involved in assessment and planning, in line with best practice. However, at the time of the site audit the service’s consultation processes with consumers, their representatives and others, was not effective. Consultation was not occurring in line with procedures and as a result, assessment and planning was not carried out based on ongoing partnerships with the consumer and others. A public guardian had not been consistently informed when the consumer’s condition changed or when incidents occurred and other service providers, allied health professionals and services were not consistently involved in assessment and planning when needed. Based on the evidence and reasoning outlined above, I find the service is not compliant with Requirement 2(3)(c).

**Requirement 2(3)(d)**

The Assessment Team found the service did not effectively communicate outcomes of assessment and planning to consumers or document them in care and service plans that were available to consumers and at the point of service delivery. The site audit report identified that most consumers and representatives felt they were not always involved in the care planning process as staff were too busy. Consumers and representatives said information was not provided to them in a timely manner. Staff said the outcomes of assessments were documented in the electronic care management system (ECMS), but they were busy, and not always able to keep care plans up to date as a result. Access to the ECMS was also restricted due to a lack of computers for staff to use.

The Assessment Team reviewed care planning documentation, including care plans, progress notes, and case conference notes for 8 consumers, which showed care planning information was outdated, contained conflicting data, and was not always communicated to all stakeholders. The Assessment Team also brought forward detailed evidence concerning several named consumers, whose care plans failed to effectively communicate outcomes of assessment planning and contained contradictory or inaccurate information and generic strategies. Information about these deficits, and deficits in others’ care plans, have been outlined in previous Requirements.

The Approved Provider’s response acknowledged the issues raised in the Assessment Team report and outlined steps to address the deficiencies in assessment and planning, which have already been outlined in other Requirements. Of note, a care conference schedule was developed and extensive steps had been planned, and some implemented, to ensure all care plans were accurate, consistent and properly communicated the outcomes of recent assessments. Not all deficits outlined in the report were directly responded to or acknowledged in the CIP, however some issues, such as staff lacking time to update care plans would be addressed through improvement actions outlined under other Requirements. The response did not, however, clearly define measures that had or would be taken to ensure sufficient computers or other devices were availed to ensure staff could update electronic care plans in a timely manner.

Having regard to the findings and the Approved Provider’s response, I find the service failed to effectively communicate the outcomes of assessment and planning in care plans that were readily available to consumers and others at the point of service delivery. Accurate and current care and services plans required for delivering safe and effective care and services were missing, compromising consumer safety. I have placed weight on evidence from staff, consumers and representatives, as well as document review evidence, which demonstrated that care plans were not kept current with assessed consumer need. As a result, I am satisfied the outcomes of assessment and planning were not clearly and consistently communicated in care plans to be available at the point of service delivery. Therefore, I find the service is not compliant with Requirement 2(3)(d).

**Requirement 2(3)(e)**

The Assessment Team recommended Requirement 2(3)(e) not met because they identified care plans were not updated as required, when circumstances changed or when incidents occurred. Specifically, review and reassessment in relation to choking risk, pain, skin, wound, and weight loss were not completed following incidents and assessments were not updated or reviewed for effectiveness following significant incidents or changes. One named consumer had not been identified as a high falls risk although staff reported frequent falls and the named consumer had not had a review or monitoring for pain or neurological conditions, in line with service’s policy. Another consumer fell but no falls risk or review was completed afterwards. The report also brought forward detailed evidence concerning other named consumers, which has been previously outlined in other Requirements.

In their response, the Approved Provider fully acknowledged the issues raised in the Assessment Team report. The response outlined a raft of improvement actions that had been planned or were in the process of being implemented, to address the deficiencies for named consumers and to improve the adherence to policies and procedures on assessment and planning, reviews and risk management. Relevant improvement actions listed in the CIP have been outlined in previous requirements. In addition, the response noted the service would carry out 3 monthly falls reviews for the one named consumer. Reassessments of their falls risk, delirium score and pain had been carried out. Other steps taken to review and update all consumer care plans have already been described in previous requirements. The response also contained an undertaking to improve its’ communication protocols so timely medical review of consumers occurs and staff are supported to provide appropriate treatment following changes in continence, pain, wound, behaviour and weight loss needs. Improvements in clinical oversight at the service were also reported in the response.

Having regard to the audit findings and the response, I am satisfied the service did not ensure care and services were reviewed when needed and as a result, care and services plans were not an accurate and current reflection of consumers’ needs, goals and preferences. I am satisfied sampled care plans did not communicate important information relating to consumer risks in the areas of falls prevention, pain, skin and weight loss. Staff were not completing and updating consumers’ assessments and plans consistently, accurately, or in line with procedures following incidents or changes in consumers’ needs. The effectiveness of strategies to manage consumers’ needs, including increased risks following incidents, changes or deterioration, were not being assessed and new strategies to effectively manage changes were not being identified and included in care plans. The service’s own monitoring systems did not identify the deficits in assessment and planning. While I acknowledge the service has already taken steps to address the deficits, as they were taken after the Site Audit, they do not demonstrate compliance. Therefore, I am satisfied the service is not compliant with Requirement 2(3)(e).

# 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. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Assessment Team recommended Requirements 3(3)(a),3(3)(b),3(3)(c),3(3)(d),3(3)(e) and 3(3)(f) were not met.

**Requirement 3(3)(a)**

The Assessment Team found consumers were not receiving effective personal hygiene care, clinical care, pain management, skin care, continence care or nutrition management. The Assessment Team identified several at risk consumers during the site audit and significant deficits in the aforementioned areas of care were identified. Relevant evidence has been outlined in several previous requirements. Other evidence brought forward by the Assessment Team is summarised below.

Consumers and representatives expressed dissatisfaction with personal care, skin care, showering and hygiene and pain management. One representative raised concern that the service’s new household model meant high care consumers did not receive the care they needed. Some consumers and representatives considered that consumers do not consistently receive necessary care due to staff being busy or temporary agency staff being unfamiliar with care needs. I have considered those comments further in Requirements 7(3)(a).

The Site Audit Report cited clinical staff who reported care staff were not trained and did not escalate changes in consumer conditions when attending to hygiene. Staff practice and lack of contemporary clinical knowledge led to misclassified wounds and the service repeatedly provided the Assessment Team with inaccurate lists of consumers with known pressure injuries.

The service did not understand current restrictive practices legislation and did not follow their policy and procedures for restrictive practices. As a result, the service did not comply with restrictive practices legislation. This has also been considered in relation to regulatory compliance governance, in Requirement 8(3)(c) and Requirement 5(3)(b) (environmental restrictive practice). The service did not have any consumers identified as being environmentally restrained. However, progress notes, interviews with consumers, representatives and staff, as well as direct observation, showed the service had a significant number of consumers who were. Some consumers were also noted to be chemically restrained and one physically restrained, without relevant requirements met by the service. This has been further considered in Requirements 5 (3)(b) and 8(3)(c).

The audit report also contained detailed consumer outcome statements, setting out detrimental impact to several named consumers. Some examples of ineffective personal and clinical care provided are outlined below.

A named consumer’s pressure injury was not identified until it was at stage 3 and it subsequently deteriorated to stage 4. The consumer’s pain was not managed and the wound had not been swabbed for infection or further investigations conducted. Wound photographs and charting were ineffective for monitoring its progression. Staff could not explain why the injury was not noticed until it was a stage 3, although staff were attending to regular massage and other care. The consumer’s medication was not reviewed, and they were not provided sufficient pain relief. A clinical nurse consultant reviewed the wound but their recommendations for treatment were not implemented properly, causing the wound to deteriorate. Significant detrimental impact to the consumer was identified, as they were known to present with non-verbal indicators of pain, including screaming on movement and when hygiene and dressing was attended. The service did not make the consumer’s legal representative aware of the deterioration or the pressure injury and an open disclosure process was not applied.

The consumer also displayed significant confusion and behaviours, however documentation review indicated these were not effectively managed or investigated. The consumer presented as underweight and it was noted that conflicting instructions were contained in the care plan and the nutrition plan, with the latter stating the consumer could feed themselves and the former stating the consumer required full assistance for eating. The consumer experienced weight loss which was not identified or managed in accordance with policies and procedure, no dietician review was actioned, and medical officer review did not occur for some time. Risk assessments were not completed where necessary.

A second named consumer was not assessed for correct positioning in their wheelchair, to assist in mobility and pain reduction, resulting skin tears were not investigated to determine their cause and were misdiagnosed as a continuing rash. Wound charts were not used as per policy and procedure. Recommendations by medical officers and physiotherapists were not followed by care staff and the consumer was environmentally restrained and could not access other areas of the service without support. The consumer’s legal representative was not consulted for medication reviews and changes in medication were made without consent. The continence care instructions in the consumer’s care plan conflicted with hygiene directives and physiotherapist directions for transfer, such that care staff had no clear instructions to follow.

Detailed evidence about other named consumers were included in the site audit report, and deficits related to continence care, hygiene care and behaviour management for those consumers have been outlined previously in Standard 1.

In their response of 1 December 2022, the Approved Provider acknowledged the deficits identified in the site audit report and set out several immediate actions taken to ensure the health, safety and wellbeing of consumers identified in the report. Those measures have been outlined previously, in Standards 1 and 2. The service had formalised clinical governance processes, by instating a weekly clinical review process with the new acting deputy service manager, clinical staff, allied health staff and team leaders, to identify specific consumer issues, documentation and assessment gaps, clinical issues and any further interventions required. Additionally, the CIP noted that skin assessments and pressure area care strategies had been updated and interventions now listed reflected assessed needs. Consumers with current wounds were reviewed and wounds were appropriately reclassified and photographed with measurements. A wound management practice lead reviewed all active wounds and skin care needs were included in regular care huddles.

The response also contained evidence steps had been taken to identify consumers who were subject to environmental or chemical restrictive practices and behaviour support plans had been put in place as required. An evaluation of the use of restrictive practices for all restrained consumers was carried out, along with ongoing review and evaluation of behaviour charting.

A review had also been conducted to identify consumers with significant weight loss and those consumers were referred to the dietician and steps taken to ensure food charting commenced. Other actions were taken and planned to address deficits around choking risk, pain management, nutrition and personal and oral hygiene. Numerous other improvement items were included in the CIP, however space limitations prevent discussion of all of these.

While I acknowledge the continuous improvement effort planned and commenced, as the steps are being implemented since the site audit, they cannot demonstrate compliance. Having regard to the audit findings and the response, I am satisfied the service did not ensure each consumer received safe and effective personal care or clinical care that was best practice or tailored to their needs. The service has demonstrated a commitment to continuous improvement and has taken action to address the deficiencies brought forward in the Site Audit Report. However, consumer and representative feedback reflected in the report and the strong weight of documentary evidence showed that at the time of the Site Audit, personal care was not being delivered in line with consumers’ preferences or needs and clinical care was not in line with expected practice and clinical care was also not delivered in line with best practice. The report identified consumers who experienced strong pain, deteriorating health and other adverse impacts as a result of the clinical and personal care provided. For these reasons, I am satisfied the service is not compliant with Requirement 3(3)(a).

**Requirement 3(3)(b)**

The Assessment Team found care plans did not consistently identify current risks or management strategies for consumers living with dementia. Ten consumers’ clinical documentation, including incident reports, progress notes, assessments and care plans showed high impact risks such as weight loss, pain, falls and behaviours were not consistently or accurately assessed. Risk mitigation and safety strategies were not consistently reviewed for effectiveness after changes or incidents, so that new strategies could be implemented to minimise recurrence of injuries or further deterioration.

The Site Audit Report also contained detailed evidence of poor management of high impact high prevalence risks, for several named consumers. This evidence has been outlined in Standards 1 and 2, as well as other Requirements in the current Standard. Furthermore, the Assessment Team found staff were not aware of current strategies to manage consumers with known risks and as outlined previously, clinical staff considered care staff were not trained and did not escalate changes to skin integrity. They raised concerns that many changes in consumer condition were not being escalated due to the high numbers of agency staff.

The Assessment Team also brought forward examples of deficiencies in the use of restrictive practices, which have been outlined in previous Standards. Staff were also unable to advise what a behaviour support plan was, where to find them and did not know what strategies should be implemented prior to the application of restrictive practice. I have considered this further in Requirements 8(3)(c). Lastly, data on high impact high prevalence incidents demonstrated incidents were not consistently identified or investigated and wounds were not consistently detected or reported in timely manner, making deterioration difficult for staff to identify.

In their response, the Approved Provider acknowledged the deficits identified in the Site Audit Report and set out several immediate actions taken to ensure the health, safety and wellbeing of consumers identified in the report. Those measures have been outlined previously, in Standards 1 and 2 and in Requirement 3(3)(a) above. Additionally, the response outlined reforms commenced or planned since the site audit, including reiteration at the service level of the organisation’s High Risk High Prevalence Protocol and Wound Management and Skin Integrity Procedure. The Approved Provider supplied evidence policies have been updated and revised based on legislation and evidence-based standards, monthly service level meetings to discuss risks including falls, infections and weight loss are occurring and staff now have a better understanding of restrictive practices requirements.

I acknowledge the service has implemented actions to address the deficits identified by the Assessment Team. However, at the time of the site audit the service was not effectively managing the high impact and high prevalence risks associated with the care of consumers. Consumers with skin integrity breakdown and pressure injuries did not have the risks managed effectively such that pressures injuries were misdiagnosed as dermatitis and repeated skin tears as a rash. Consumers with a history of falls did not have their falls risk re-assessed and updated strategies put in place. Choking risks were not identified and risk mitigation strategies not used. Consumers were restricted environmentally, physically and chemically, without consistent monitoring to determine the impact to those consumers. Consumers with dementia did not have tailored behaviour support plans, and staff were unaware of how to manage escalations effectively. The service did not ensure consumers receiving chemical restraint were trialled with non-pharmacological strategies prior to the administration of a restrictive practice. Having regard to the audit findings and the response, I am satisfied that at the time of the Site Audit, the service did not consistently demonstrate effective management of high impact and high prevalence risks for each consumer. Therefore, I am satisfied the service is not compliant with Requirement 3(3)(b).

**Requirement 3(3)(c)**

The Assessment Team found the service did not ensure the needs, goals and preferences of consumer nearing the end of life were recognised and addressed, their comfort maximised and their dignity preserved. The Site Audit Report brought forward evidence concerning 4 named consumers, two of which have been previously discussed in relation to Requirement 2(3)(b). Of the additional two consumers, one had not had their pain medication reviewed for end of life care and care staff did not know they were palliating. The Site Audit report brought forward evidence of a further consumer whose palliative care plan stated their end of life wishes were to be respected but did not say what their wishes were. Documentation showed no review by a medical officer or palliative care clinical nurse consultant was conducted for that consumer. Another consumer’s advanced care directive did not contain clear directions for resuscitation. Observations showed an end of life wish of that consumer was not being respected during the site audit.

In their response of 1 December 2022, the Approved Provider acknowledged the deficits identified in the site audit report and outlined that the named consumers have had a clinical risk review by the Clinical Nurse Consultant and the Palliative Practice Lead to ensure risks are minimised and specialised nursing care needs identified. Consumers receiving palliative care have been referred to their Medical Officer in partnership with the palliative care nurse. The Medical Officer reviewed pain management strategies and pain has been assessed and evaluated on the ECMS. The end of life pathway checklist has been reintroduced to support a person centred and holistic approach to improve symptom management leading to better end of life care.

While I acknowledge the service had taken or plans to take appropriate action to address deficits in end of life care, I am satisfied the service did not ensure consumers who were nearing end of life were being monitored effectively for pain or having their comfort maximised. Staff could not identify which consumers were palliating and the service could not demonstrate sampled consumers had been reviewed by the palliative care team. At the time of the Site Audit the service was unable to demonstrate the needs goals and preferences of consumers nearing end of life were recognised or addressed, or their comfort maximised. Therefore, I am satisfied the service is not compliant with Requirement 3(3)(c).

**Requirement 3(3)(d)**

Regarding Requirement 3(3)(d), the Assessment Team found the service did not effectively ensure deterioration in each consumer’s condition was recognised and responded to in a timely manner. Although the service had a clear process for the escalation of any change or deterioration in a consumer’s health or wellbeing, the service was not effectively following it. Evidence brought forward to support their finding is outlined below.

As outlined previously, clinical staff raised concerns that care staff were not sufficiently trained and did not escalate changes in consumers, such that clinical staff were not supported to identify and address deterioration. Pressure injuries were misdiagnosed. Some consumers and representatives were not confident the service would respond in a timely manner to effectively address any deterioration in a consumer’s health status as they considered the service was short staffed, and the staff did not always have time to respond. Detailed evidence concerning two named consumers was brought forward in the Site Audit Report, including one consumer whose unstageable pressure injury was not identified until late stages, which has been outlined previously. Other evidence to show deteriorations and changes were not recognised or effectively responded to included but was not limited to a consumer with ongoing agitation, refusal of hygiene care and other signs potentially related to an ongoing medical condition, all of which were not investigated further.

The Approved Provider acknowledged the deficits identified in the site audit report and provided some further information to clarify inaccuracies in the report. The response also set out several immediate actions taken to ensure the health, safety and wellbeing of consumers identified in the report. Those measures have been outlined previously, particularly in Standard 2 and in Standard 3(3)(a). Concerning the named consumer discussed in the previous paragraph, the service had conducted a review of the consumer’s care needs, and steps were being taken to investigate issues highlighted in the report. Concerning the consumer with the late state pressure injury, actions taken to address risk for that consumer were outlined in Requirement 1(3)(a). Additionally, the CIP indicates the Approved Provider has commenced reading progress notes regularly to identify changes in consumers’ condition and to ensure timely follow up and medical reviews are carried out. Other improvements in clinical governance and oversight have also been outlined in previous Requirements.

I acknowledge the service has taken action to address the deficits identified by the Assessment Team. However, at the time of the site audit the service did not have effective systems to ensure deterioration in consumers’ condition was recognised and responded to appropriately or in a timely manner, particularly in relation to pain, agitation and skin integrity. Care staff were not supported to recognise and respond to changes in skin condition particularly, and identifiable impact to consumers was identified as a result. Consumers identified have required further assessment and strategies to be implemented to manage the deterioration since the deficits were identified by the Assessment Team. The service’s own monitoring systems did not identify the deficits in the staff not recognising and responding to deterioration. Based on the reasoning and evidence outlined above, I am satisfied the service is not compliant with Requirement 3(3)(d).

**Requirement 3(3)(e)**

Regarding Requirement 3(3)(e), the Assessment Team found the service did not ensure information about consumers’ individual needs, preferences, and condition were documented and communicated to relevant persons. Staff interviewed were not aware of consumers’ care needs and preferences, said they were not always able to access the care plan and so relied heavily on verbal handovers. Staff said they did not have sufficient time to consistently update care plans and did not confirm care plans were current and supported sharing of information. Staff also said agency staff did not consistently update care plans. Risks for 4 consumers were not identified in recent handover sheets reviewed by the Assessment Team including risk information relating to 2 consumers’ weight loss and 1 consumer’s unwitnessed fall. Other information about COVID-19 exposed consumer had not been communicated to staff at their handover, during the site audit. Lastly, a representative gave multiple examples of detrimental impacts to a named consumer from poor communication of consumer need within the service, including the consumer having their scheduled surgery postponed as a result of poor or no communication between staff in the service and repeatedly having their religious meal requirements not adhered to. Lastly, as discussed in previous Requirements, numerous reviewed care plans contained inconsistencies and inaccurate information, indicating systemic deficits in the communication of consumers’ condition, needs and preferences.

In their response, the Approved Provider acknowledged the deficits identified in the site audit report and set out numerous planned and implemented improvements, which have been outlined previously, particularly in relation to defects in a care planning documentation. In addition, the Approved Provider’s response stated that consumer dietary preferences have been communicated to the kitchen and to staff members in line with care planning documentation. The PCI indicated the Approved Provider will ensure there is regular handover between shifts to ensure continuity of care is upheld and management will monitor and correct information gaps.

Having regard to the audit findings and the response, I am satisfied the service did not ensure information about each consumers’ condition and needs were documented and effectively communicated throughout the organisation. The organisation did not effectively communicate changes in consumers’ condition and needs, through handovers and through care planning documentation. Risks were not identified or communicated during the handover process which did not ensure the delivery of safe and effective personal and clinical care**.** At the time of the Site Audit the service was unable to demonstrate changes to consumers’ condition had been documented and communicated within the organisation. I have also had regard to information outlined in Requirement 2(3), which showed information was not consistently shared with representatives with shared responsibility for care. Based on the reasoning and evidence outlined, I am satisfied the service is not compliant with Requirement 3(3)(e).

**Requirement 3(3)(f)**

Regarding Requirement 3(3)(f), the Assessment Team found a referral process was in place, but the service could not demonstrate referrals were being carried out in a timely and appropriate manner. Information about various named consumers who were not referred on to relevant allied health and other professionals, such as dieticians, dementia services, medical officers and speech pathologists has been outlined in previous Requirements. Additionally, the service physiotherapist confirmed they had not received referrals for some consumers and advised they only reviewed consumers every 6 months if a referral was received. Some consumers’ swallowing risks were not identified and therefore risk management strategies from an appropriate professional were not implemented, assessment for positioning in a wheelchair for one consumer was not attended to by an appropriate professional resulting in skin tears and pain, a consumer’s behaviors were ineffectively managed and a dementia service was not engaged, resulting in impacts to those consumer’s dignity and wellbeing.

In their response, the Approved Provider acknowledged the deficits and outlined various clinical governance and oversight improvements that would be made, several of which have been outlined in previous Requirements. Additionally, the response noted the following actions have been or are in the process of being implemented**.** All identified consumers with behaviours of concerns were referred to DSA following consultation with representatives. Consumers with chronic wounds and existing pressure injuries have been referred to the clinical nurse coordinator for a complex review and have also been seen by the Medical Officer. The Approved Provider has since formalised and revised weekly reviews with involvement of allied health to discuss concerns and clinical issues identified and will organise follow up reviews and further interventions as needed.

Having regard to the audit findings and the response, I am satisfied the service did not ensure consumers were not referred to organisations or providers of care to meet the individual consumer’s needs. I acknowledge the Approved Provider’s actions since site audit to address the deficits, however at the time of the Site Audit, the service did not essential referrals were made, to ensure consumers’ health and wellbeing were being maintained and risks managed. I find there were detrimental impacts to some consumers as a result. Based on the reasoning and evidence outlined above, and throughout the report, I am satisfied the service is not compliant with Requirement 3(3)(f).

I am satisfied the remaining Requirement of Quality Standard 3 is compliant.

Staff described how they minimised infection-related risks and managed the use of antibiotics, confirming they had received training to support their practice. The service had policies and procedures in place for antimicrobial stewardship and for the prevention of outbreaks. The Assessment Team observed staff following the current personal protection equipment (PPE) guidelines and other infection transmission prevention measures were taken. Some deficiencies in pathology referral and follow up processes were identified and the infection register reflected an increase in infections. On balance, the Assessment Team found Requirement 3(3)(g) was met.

# Standard 4

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

Findings

The Assessment Team recommended the following Requirement was not met:

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

The Assessment Team received mixed feedback regarding the meals. As previously outlined, one representative reported religious dietary requirements were not consistently respected and the consumer received the same food frequently and as a result, the family provided meals to ensure their needs were met. Another named consumer enjoyed breakfast but considered other meals were overcooked and as a result, they requested sandwiches rather than consuming the hot meals. A different named consumer also considered the meals overcooked and was provided supplementary food by their family to eat when she does not like the meals served. A third named consumer also disliked the meals and expressed that their dietary preferences were frequently disregarded, and they were served ingredients they did not eat. Management reported a trend in complaints about food; and lastly, an annual consumers’ survey showed that 33% of consumers liked the food ‘some of the time.’

In their response, dated 1 December 2022, the Approved Provider acknowledged the issues raised in the Assessment Team report and outlined several improvement actions which had been planned or implemented, to address the deficiencies. The response gave assurances religious dietary needs have been identified, assessments would be carried out when there is a change in dietary requirements, a dietary needs change form had been implemented, a food survey had been carried out and the results analysed and actioned. Snacks were made available throughout the day. A food forum group has been established and the first forum held, where consumers had the opportunity to provide feedback regarding the dining experience and food choices.

I am satisfied the service is working to improve meal quality and variety for consumers and has identified appropriate improvements. However, I have placed considerable weight on consumer feedback to find that at the time of site audit, meals were not consistently of high quality and consumers’ dietary requirements were not always met. I have also considered feedback from one representative that they had raised concerns prior to the Site Audit and I have attributed weight to evidence some families routinely provide meals for consumers. While I acknowledge the steps being taken to address the deficits these will take time to embed and changes taken after site audit do not demonstrate compliance. Therefore, I am satisfied the service is not compliant with Requirement 4(3)(f).

I am satisfied the remaining 6 Requirements of Quality Standard 4 are compliant.

Consumers and representatives were mostly satisfied with the lifestyle program and supports for daily living; they felt at home and their needs, goals and preferences were met which optimised their health and quality of life. Lifestyle staff knew consumer lifestyle preferences and said their needs informed the lifestyle program. A range of activities were observed during the Site Audit such as happy hour, live entertainment, social coffee gathering and bus trips.

Consumers said they felt supported to maintain social, emotional, and religious connections which were important to them. Care staff provided examples of how they supported consumers' emotional and psychological well-being. Pastoral staff organised visits from other religious organisations.

Overall, consumers said they were supported to do things within and outside the service. Consumers described how they kept in touch with people important to them. Staff described how they supported consumers to participate in activities, and this aligned with care planning documents.

Staff confirmed that changes to a consumer's care relevant to lifestyle and activities of daily living were shared and recorded in the consumer's ECMS and communicated via handovers. Examples of effective information sharing to support consumers’ lifestyle needs were identified.

Consumers and representatives confirmed the service would refer them to an appropriate provider of lifestyle supports. Lifestyle staff understood which organisations, services, and supports were available in the community. The service used a community visitors’ scheme and volunteers.

Consumers said the equipment was readily available and suited to their needs. An external maintenance contractor was used.

# 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. | Non-complaint |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Assessment Team recommended the following Requirement was not met:

* The service environment:
  + is safe, clean, well maintained and comfortable; and
  + enables consumers to move freely, both indoors and outdoors.

Consumers and representatives stated the service does not enable them to move freely both indoors and outdoors. An electronic fob was required for exit and entry on each level. Consumers reported there were long delays in waiting to be taken downstairs as staff were not always available. Several consumers reported they were unable to go to the coffee shop, use the balconies or leave the service unless escorted by a staff member or without a member of staff unlocking the doors.

Staff confirmed only some consumers can access the community coffee shop and have swipe access to leave the floor levels, on their own. Staff expressing it was dangerous for consumers to leave the service on their own. Staff also confirmed that due to short staffing and workloads they are not always able to escort the consumer when requested. Refer to Requirements 1(3)(d) and 3(3)(a) where environmental restraint is also discussed.

The Site Audit Report also reported Assessment Team observations, including an agitated consumer who was locked out of the service on a balcony during the audit, for a period of 5 minutes, knocking to gain access. By the end of the site audit, access to balconies had been granted. The Assessment Team was provided a list of consumers who had fobs but could not say how many had retained possession of fobs and as many families kept the fobs to access the service. Management, as a result, were unaware which consumers could move about freely, however staff indicated a very low number of consumers who could.

The not met recommendation relied on evidence that various areas of the service and equipment were not very clean, including a utility room and other fittings. A cytoxic waste bin in a utility room was observed to be unlocked. Kitchenettes on various levels were found to be untidy, and care staff expressed under the new care model, they were expected to do a lot more cleaning and considered there was insufficient staff to do it all. A consumer expressed the cleaning was not good and a representative confirmed cleaning the consumers on a weekly basis. Lastly, fire safety equipment was not found in the smoking area, which was rectified during the audit.

In their response, dated 1 December 2022, the Approved Provider fully acknowledged the issues raised in the Assessment Team report and took immediate steps to address the wide spread deficits, as outlined in Requirement 1(3)(a). In addition, the response gave assurances staff would be educated on the need to balance consumer choice and risk and would be trained to improve practice in that regard. The PCI also noted several improvement actions, some of which were planned or already implement. Concerning environmental restraints, the service had identified all consumers subject to restraint and gave an undertaken to evaluate the use of restrictive practices on those consumers and ensure all compliance documentations were compiled and ongoing reviews occurred. Further fobs were to be purchased and the PCI indicated all consumers had been given access to balconies. The PCI also included several steps planned to address cleanliness concerns, including increase management engagement with the external cleaning services, training for staff on cytotoxic management and a cleaning schedule provided to the service’s external cleaning contractors. Regular management walk-arounds were planned, to monitor the service environment.

While I acknowledge the Approved Provider has identified and started to implement appropriate steps to address the deficiencies identified in the Site Audit Report, steps taken after Site Audit cannot demonstrate compliance. I am satisfied that at the time of audit, many consumers’ movement inside and outside the service was restricted, without legal requirements being met. Staff were not aware of restrictive practice requirements and staff felt unable to complete cleaning requirements in time allocated them under a new model of care at the service. As a result, kitchenettes of the service were not cleaned to the requisite standard. Other areas of the service contained some hazards or lacked necessary safety equipment. Based on the evidence and reasoning outlined above, as well as evidence discussed previously in Requirement 1(3)(d) in particular, I find the service environment was no clean or well-maintained and did not support consumers to move freely. Therefore, I am satisfied the service is not compliant with Requirement 5(3)(b).

I am satisfied the remaining 2 Requirements of Quality Standard 5 are compliant.

Regarding the remaining Requirements, consumers and representatives said they felt at home living and the service environment was welcoming and comfortable. Observations showed 2 external gardens on Level 1 of the service, one of which was predominately for smokers. Consumers were encouraged to personalise their room with their belongings. The Assessment Team observed the environment was comfortably furnished with multiple areas for consumers to meet with their family, friends and other consumers to socialise.

Consumers and representatives said the service provided equipment which was safe, and well-maintained. The service had a preventative and reactive maintenance program in place. All maintenance was undertaken by an outside contractor located onsite. However, the Assessment Team observed some furniture for consumer use was unclean, including dining chairs and tables. Management reported care staff were responsible for cleaning chairs and tables. The Assessment Team did not see cleaning schedules for care staff.

# 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. | Non-compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The Assessment Team recommended Requirements 6(3)(b), 6(3)(c) and 6(3)(d) were not met.

**Requirement 6(3)(b)**

The Assessment Team recommended Requirement 6(3)(b) was not met, as the service did not demonstrate consumers and representatives were aware of or had access to, advocates, language services and other methods for raising and resolving complaints. Consumers and representatives said they were not aware of advocacy and translating services, despite the service having a high percentage of consumers from culturally and linguistically diverse backgrounds. Most staff did not know what advocacy services were and described relying on body language and gestures to determine when consumers were unhappy. Management described the last instance an interpreter was accessed being a year prior to site audit. One named consumer had not been offered an interpreter for raising and resolving complaints, and expressed concern at burdening their representative who had to raise concerns on their behalf.

In their response, of 1 December 2022, the Approved Provider acknowledged the deficits identified in the site audit report and took immediate steps to respond to the audit findings, as previously outlined in Standard 1. The response also confirmed that contact information for advocacy and translating and interpreting services was now displayed in the service. The PCI provided with the response indicated a review of all open incidents was underway and the use of advocacy services has been discussed at relative and consumer meeting, since the site audit. A care conference with the named consumer and their representative occurred, to address concerns raised with the Assessment Team. As previously outlined, the response contained an undertaking to partner with cultural diversity services, to improve the service’s performance in working with consumers from CALD backgrounds.

Having regard to the audit findings and Approved Provider’s response, I find the service did not demonstrate consumers were made aware of, or able to advocates and language services, or other methods for making external complaints. The service had not taken basic steps to ensure consumers had information about, or access to services needed to support them in raising external complaints. While I acknowledge the CIP and response demonstrated the service has taken some steps to address the issues, steps taken after site audit do not demonstrate compliance. Significant improvements in use of interpreting services and provision of translated material is required, to ensure linguistically diverse consumers have equal access to complaints and feedback mechanisms. The service’s reliance on unaccredited, informal interpreters raises the concern that non-English speaking consumers cannot easily provide feedback or raise concerns themselves, at a time that suits them. Multilingual staff, family members and representatives cannot always be available to interpret and there are risks in using non-accredited interpreters, including possibility of errors or consumers not having their concerns accurately conveyed. For these reasons, I am satisfied the service is not compliant with Requirement 6(3)(b).

**Requirement 6(3)(c)**

The Assessment Team recommended Requirement 6(3)(c) was not met, as most representatives and consumers reported the service did not acknowledge their complaints and information regarding the outcome of complaints was not provided to them. Repeated requests for a documented complaint register were put to management, however none was provided and management contended that most complaints were dealt with immediately by staff and not documented. However, interview evidence provided to the Assessment Team indicated otherwise. One named consumer and a representative had raised complaints with the service, about a concerning personal care allegation and serious miscommunication incident, respectively; however both were dissatisfied and did not receive any formal response to their complaints. Other consumers and representatives, as well as staff, outlined previous complaints they had made about a range of issues, including provision of food that contravened religious requirements, slow call bell response times and an incident where a consumer missed a scheduled surgery due to an error with their medication. These complaints did not result in appropriate action and were generally not documented in the incident/complaint register. The complainants did not receive apologies. Overall, evidence did not demonstrate the service had a functioning and effective system for identifying, acknowledging or documenting complaints, investigating concerns or practicing open disclosure.

In their response, dated 1 December 2022, the Approved Provider acknowledged the issues raised in the Assessment Team report and took actions, as outlined in Standard 1, to commence a significant improvement process as the service, to ensure the immediate and ongoing health, safety and wellbeing of named consumers. The CIP indicates there has also been a review of the complaints log for the previous 3 months and all complaints have been acknowledged, responded to and actioned to make improvements. All consumers and representatives highlighted in the Site Audit Report had been contacted and their feedback and complaints were addressed.

While I acknowledge the Approved Provider has taken appropriate steps to ensure complaints recently made at the service are documented and handled in a systematic way, with outcomes reached and actions evaluated, steps taken since site audit cannot demonstrate compliance. The service did not have a functioning system for responding to complaints, verbal complaints and complaints from other sources were not routinely documented, trended, reviewed or follow up actions evaluated. I am satisfied consumers’ complaints about their dietary and religious requirements and other significant care matters did not result in appropriate action. Complainants were not advised of outcomes and did not receive apologies where open disclosure was necessary. Based on the evidence and reasons outlined above, I find the service is not compliant with Requirement 6(3)(c).

**Requirement 6(3)(d)**

The Assessment Team recommended Requirement 6(3)(d) was not met, as most consumers and representatives were not confident their feedback and complaints resulted in improvements at the service. Staff said email complaints were not actioned or responded to and they had not seen any changes made in response to their feedback. Detailed concerns about one named consumer were put forward to support the not met recommendation and the Assessment Team also relied on management’s account of complaints trends at the service, which was inconsistent with the complaints/ incident register provided for review. The register contained only 5 complaints/incidents and review of the document demonstrated no clear process to respond, take follow-up action or evaluate the response. The complaints did not appear in the continuous improvement register reviewed during the site audit.

The Approved Provider’s response acknowledged deficits in handling of complaints and the failure to use complaints and feedback to drive continuous improvement. The response contained various undertakings to address the deficits, including a promise to promote a culture of learning and improvement, to use open disclosure and undertake root cause analyses in response to serious incidents. The CIP contained detailed outcomes the service will work toward, to ensure the service’s existing reporting system was properly utilised to capture and analyse consumer feedback and complaints and use them to inform continuous improvement. The CIP also showed staff refresher training on responding to complaints and feedback had been scheduled.

While I acknowledge the Approved Provider has identified appropriate steps to ensure the service will use complaints and feedback to inform continuous improvement at the service, staff and management behaviours will require time to change and new habits in complaints management will require time and repeated practice to become embedded. Furthermore, steps taken after site audit cannot demonstrate compliance. Having had regard to the evidence in the site audit report and the response, I am satisfied the service did not have an effective system and process to identify, document and analyse complaints received at the service, and as a result, did not use complaints to inform the continuous improvement program. For these reasons, I find the service is not compliant with Requirement 6(3)(d).

I am satisfied the remaining Requirement in Quality Standard 6 is compliant.

Consumers and representatives said they felt comfortable raising concerns or making complaints and felt they could speak to staff or management. However, the Assessment Team observed just one suggestion box on the ground floor with feedback forms in a different location. Signage to direct consumers to the suggestion boxes was not observed.

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

Findings

The Assessment Team recommended Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(d) were not met.

**Requirement 7(3)(a)**

Regarding 7(3)(a), the Assessment Team found that while the service had a planned approach to rostering, the approach was not effective in ensuring the right number and mix of staff were deployed. Most consumers and representatives interviewed said there were not enough staff and gave numerous examples of detrimental impacts experienced by consumers as a result of inadequate staff mix and numbers. One representative gave feedback the new household model of care was ineffective for high care consumers. Consumers requiring 2-person assistance said they frequently had to wait for a second staff member to become available, others said they wanted to socialise at the downstairs café but were frequently told there was no one to assist them. Others said call bell waits were extended at times of short staffing, while numerous representatives said there was a lack of staff to provide care and assistance with lifestyle activities. A representative said care staff were often seen doing laundry, working in kitchenettes and organising laundry as well as cleaning consumer rooms, preventing them from spending time with consumers.

Staff interviewed confirmed there was insufficient personnel to meet care needs and to provide safe and timely care and services to consumers. ‘Homemakers’ in each house were responsible for a wide range of tasks in addition to providing care, including medication rounds and supporting consumers per the activities calendar, as well as cleaning and laundry tasks. Homemakers interviewed said they could not complete tasks and provide 1:1 support according to the activities calendar. Management confirmed that increased need of consumers had lessened the viability of the household model with the staff numbers employed at the time of audit. Review of rosters showed extensive vacant shifts, which were offered to permanent and casual staff first, before being offered to agency staff. The service relied heavily on agency staff, however had commenced recruitment to add an additional 20 care staff. Call bell data indicated long between breakfast and dinner times.

The site audit report also brought forward negative consumer outcomes for 3 named consumers, to support the not met recommendation. These consumer outcomes have been outlined previously in relation to Requirement 3(3)(a) and 1(3)(a), and included concerns about missed consumer pressures injuries, poor wound care, insufficient staff to support consumers to leave their rooms and socialise, as well as extensive wait times for transfers, personal and hygiene care.

The Approved Provider’s response of 1 December 2022 acknowledged the deficits identified in relation to staffing numbers and mix, and it outlined measures planned or being implemented, to address issues identified during the site audit. The response noted the service was working to implement systems to ensure staff numbers were maintained, including unplanned leave shifts and that mechanisms were in place to review staff mix and numbers as consumer needs changed. The CIP noted a recruitment drive was underway, with 19 employee candidates interviewed shortly after site audit; and it contained undertakings for management to regularly review client acuity against staffing capabilities. A detailed roster review was also planned.

I acknowledge the Approved Provider’s response and the steps they have planned and are implementing to address deficits in staffing numbers and mix. However, steps taken after site audit do not demonstrate compliance. While I acknowledge the service has a planned approach to rostering and recruitment, I find the number and mix of personnel deployed has not enabled the consistent delivery of quality care and service. Having regard to the site audit report and the provider’s response, I am satisfied that care staff numbers were insufficient to ensure provision of safe and effective personal care and to ensure lifestyle needs and social needs of consumers were met. Insufficient care staff numbers also appear to have contributed to deficits in pressure injury prevention and monitoring and potentially, failure to identify and escalate deterioration and other concerns as needed. I have placed significant weight on consumer, representative and staff feedback, to find that transfers and hygiene care were also impacted by the insufficient staff numbers. For these reasons, I am satisfied the service is not compliant with Requirement 7(3)(a).

**Requirement 7(3)(b)**

Consumers and representatives generally spoke positively about staff and most said permanent staff were kind, caring and did their best to provide personal care and support to consumers, however two representatives expressed concern that cultural requirements were not respected. The Assessment Team also observed that interactions during a meal service were rushed and staff were short when talking to consumers. The not met recommendation was also supported by observations made of staff arguing with a consumer who was escalating, despite the consumers’ need for calm interactions when they were agitated. Observations also showed several staff not waiting to be granted permission before entering consumer rooms. One staff member also failed to acknowledge a consumer at all, after entering their room without knocking first.

The Approved Provider’s response of 1 December 2022 acknowledged the deficits identified in relation to staffing numbers, and it outlined measures planned or being implemented, to address issues identified during the site audit. The response noted spiritual care training and performance review conversations would be extended to all staff, to ensure consumer rights to kindness, care, respect were met. A training needs analysis was planned, to identify further training requirements for staff. Other relevant improvement actions planned or implemented have also been outlined previously in Standard 1.

While I acknowledge the service has taken and will take steps to address the concerns identified in the site audit, steps taken after audit cannot demonstrate compliance. I also acknowledge that consumer and representative feedback was generally complimentary of staff, however I have placed greater weight on the direct observations of the Assessment Team, which showed staff did not always treat consumers with dignity and respect. The direct observations, as well as evidence already outlined in Standard 1, demonstrates that interactions were rushed or generally not conducive of consumer well-being and dignity, and ineffective and inappropriate interactions with an escalating consumer placed them at risk of accidental injury. Multiple consumers’ diverse cultural and religious needs were not respected. For the reasons outlined above, I find the service is non-compliant with Requirement 7(3)(b).

**Requirement 7(3)(c)**

Consumers, representatives and staff gave mixed feedback concerning workforce competence. Some consumers said they felt comfortable with the personal care provided by permanent staff, however, others were not satisfied all staff provided effective personal and clinical care to consumers. Most consumers were dissatisfied with agency staff and preferred they did not provide their personal care. For example, one consumer was concerned about agency staff completing wound dressings, another consumer said agency staff do know their needs and a third consumer said they felt uncomfortable when only agency staff completed their two-person transfers.

Registered Nursing staff reported concerns care staff were undertaking observations they did not have the competence or knowledge to perform, were practising outside their scope of practice and had not been escalating concerns and issues with consumer health and wellbeing in a timely manner. Examples included consumers who were incorrectly identified has having dermatitis which were actually pressure injuries, in the month prior to site audit. In the month prior to audit, other named consumers were identified with a stage 2 pressure injury, a severity level 3 recurring wound and a pressure injury described as a ‘sore bottom’, respectively, which care staff had not escalated to RNs in a timely manner. Although the service’s training calendar identified several pressure injury and wound care trainings throughout 2022, attendance rates were low across all training modules.

During the site audit, management acknowledged care staff and homemakers were working outside the scope of practice, had not attended requisite trainings and were failing to escalate change in a timely manner.

The Approved Provider’s response of 1 December 2022 acknowledged the deficits identified during site audit and outlined a comprehensive list of planned and implemented actions designed to address the deficiencies. The CIP noted the service’s skill matrix had been reviewed and new management had followed up on overdue assessments. Local training calendars were developed by clinical nurse educators and an undertaken given that regular skills assessments/ competencies would be completed relative to staff scope of practice. Nursing staff were reminded of their position descriptions and expectations, as well as the scope of their roles, and care staff had received similar counselling at a staff meeting.

Having had regard to the evidence in the site audit report and the response, I am satisfied not all members of the workforce were competent or had the knowledge to effectively perform the roles they were assigned to. I have placed weight on RN interview evidence that care staff were operating outside of scope and that there were detrimental outcomes to several consumers as a result, particularly where pressure injury identification and management was concerned. The response contained some indication the service is taking steps to address competence and scope of practice issues, however as these steps were taken after site audit, they cannot demonstrate compliance. At the time of the site audit evidence shows staff were not effectively performing their roles and were not maintaining the competencies and knowledge to do so. For these reasons, I find the service is not compliant with Requirement 7(3)(c).

**Requirement 7(3)(d)**

The service demonstrated they have organisation wide staff training and education systems in place and platforms to recruit and orientate new staff. The service was, however, not able to demonstrate the workforce is trained, equipped and supported to deliver outcomes required by the Quality Standards. Although there were policies and procedures in place to monitor staff training, service practice was not aligned with these and many staff training modules were incomplete at the time of audit. Consumers said personal care provided was not of good quality, care, clinical and management staff did not understand restrictive practices and requirements for their use, staff had little understanding of dignity of risk and consumers’ freedom of movement was restricted, purportedly to address safety concerns, without necessary risk assessments to justify this. Training sessions on dignity and risk were poorly attended, with only 10% of staff involved. Management did not have an effective system for tracking staff training completion.

The provider’s response of 1 December 2022 acknowledged the deficits identified during site audit and outlined a comprehensive list of planned and implemented actions designed to address the deficiencies. Concerning deficits in training and staff members’ lack of understanding of the Quality Standards, an undertaking was given that a Training Needs Analysis would be completed and local training calendars were developed by clinical nurse educators, to address deficits. The CIP outlined several areas for refresher training for staff, including in relation to dignity of risk and restrictive practices.

While I acknowledge the service has identified some relevant improvements to address the deficits in practice identified during the site audit, as the steps are being taken after site audit, they cannot demonstrate compliance. I am satisfied the service was not effectively implementing the organisation’s staff training and education procedures and the lack of training was mirrored by clear deficits in practice, particularly in relation to dignity of risk and restraint. Personal care provided was also not in line with the Quality Standards. At the time of the site audit deficits in staff skills were not identified and steps were not taken to ensure staff had completed relevant training and were supported and required to perform their roles effectively. Therefore, I am satisfied the service is not-compliant with Requirement 7(3)(d).

I am satisfied the remaining Requirement in Quality Standard 7 is compliant.

Staff confirmed their performance was monitored through performance appraisals. Management described the performance appraisal process and were able to provide examples of appraisals completed by staff.

# Standard 8

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

Findings

The Assessment Team recommended Requirements 8(3)(b), 8(3)(c), 8(3)(d), and 8(3)(e) were not met.

**Requirement 8(3)(b)**

Consumers and representatives gave mixed feedback when asked whether the service was well-run. Most said the environment was not inclusive, as very few consumers could access all areas of the service and could not socialise or make friends with consumers from the across the service. Consumers raised repeated concerns about various areas of clinical and personal care, as previously outlined. Care staff did not consider the household model to be effective and expressed they were unable to provide quality services, as they were diverted to cleaning, laundry and food services tasks rather than their core duties. The audit report also relied on other evidence previously outlined, concerning care staff operating outside their scope of practice, and failing to escalate changes and deterioration. The Assessment Team also outlined deficits in documentation and reporting, as a result of inadequate staff numbers. The report noted that while the organisation had a strategic plan and monitored the service’s performance through the information reporting in the ECMS, the organisation was reliant on the service itself to gain an accurate picture of what occurred in practice. There were numerous gaps in information recorded in the ECMS, such that information relied on by organisation and service management for monitoring purposes, was unreliable and did not give an accurate picture of the service’s performance. The board was said to want a more visible presence at the service, however had not managed to achieve this by time of site audit.

The provider’s response of 1 December 2022 acknowledged the deficits identified during site audit. The response and CIP listed several planned and implemented actions to address the deficiencies, including reinforcing with staff the need to implement the numerous systems and processes that were already in place to support governance of the service, but were not being consistently used, The response noted that ‘Back to Basics’ training covering core areas of care will be implemented and the CIP confirmed clinical trending analysis of the previous quarter’s reporting data had been completed since the site audit and a monthly governance report had been produced covering falls, incidents, skin and pressure injuries, infections, reportable incidents, psychotropic medications, weight and restrictive practices management. The CIP also stated that the service had collaborated with a service excellence process specialist to review and evaluate implementation of the household model, however the response did not clearly communicate the outcome of that review and evaluation, making it difficult to ascertain how the service was responding to concerns expressly raised about the model. Other improvement actions taken were outlined, however space limitations prevent discussion here.

While I acknowledge the service has identified several appropriate actions to address the deficits outlined in the report, steps taken after site audit cannot demonstrate compliance. Furthermore, numerous shifts in practice are required to both improve staff performance and ensure that data relied on in clinical governance reports is accurate and capable of assuring the governing body that the Quality Standards are being met. Such changes will take time to implement and embed. I have also considered that the existing governance arrangements did not identify the extensive non-compliance at the service. Based on this reasoning and the evidence outlined in this Requirement and throughout the report, I am satisfied at the time of site audit, the governing body was not promoting a culture of safe, inclusive and quality care and services and was not accountable for their delivery.

**Requirement 8(3)(c)**

The Assessment Team identified deficits in all organisation-wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

Information management

The not met recommendation was based on evidence that the service’s multiple information systems were ineffective for ensuring all information was current, accurate and shared with stakeholders in line with the service’s policies and procedures. Numerous examples of conflicting information contained in care planning documentation were cited throughout the report, such that staff had no clear instructions to provide safe and effective care and services to sampled consumers. Verbal complaints were not documented and monthly complaints data was inaccurate as a result. The incident management systems recorded very few incidents and did not include all information required by law. Consumers said they did not get the information they needed to make choices about care and lifestyle activities and ‘resident and relative’ meeting minutes were not distributed.

Continuous Improvement, Feedback and complaints

Concerning Continuous Improvement and feedback and complaints, the service did not demonstrate they followed their own policies and procedures. Evidence relied on has been outlined in previous requirements and focussed on the lack of accurate complaints and incident data and lack of a complaints handling process with supporting documentation, such as a dedicated complaint register. As a result, the organisation’s management and the governing body did not have an accurate picture to support evaluation of progress against the strategic plan, the service’s continuous improvement plan or overall performance.

Workforce governance

Deficits in relation to workforce planning, training and performance have been outlined in Standard 7. Notably, care staff were found to be operating outside of scope, demonstrating a failure to assign clear responsibilities.

Regulatory compliance

Significant deficits in the service’s management of restrictive practices were outlined in Standard 1, 3 and 5. Notably, a significant number of consumers were subject to environmental restrictive practices and were, effectively, restricted from socialising in communal areas. Consumers subject to restraint were not identified as such, and as a result, regulatory requirements such assessment to justify the use of the restraint, informed consent and ongoing monitoring and evaluation were not completed.

In their response of 1 December 2022, the provider acknowledged the deficits outlined and provided a continuous improvement plan, to support a return to compliance. The plan contained several undertakings, including that the organisation’s Corporate and People team would provide support and oversight of workforce planning and development of related policies and procedures, while the regional Quality Team would provide oversight of compliance and monitor performance through auditing and analysis of quality and clinical data. The response also gave an assurance the service would implement regular case conferring, provide ‘Back to Basics’ training for staff and would make available ‘quick reference guides’ to support staff in their handling of complaints and feedback. The service’s archiving process was also reviewed.

I acknowledge the service is taken appropriate steps to address the deficits outlined in the Site Audit Report. I also acknowledge the service has access to relevant organisational policies and procedures to guide practice. However, the service does not consistently follow the organisation’s procedures and has not ensured staff practice aligns with those. The service did not demonstrate information management, human resources, continuous improvement, feedback and complaints or regulatory compliance systems were effective at the time of the site audit based on the evidence and outcomes above. Information about consumers’ clinical and personal care needs were not accurately gathered, assessed, documented or communicated, resulting in deficits in personal and clinical care delivered. The service had not accurately completed feedback and complaints logs or incident logs to ensure areas for improvement were identified and other monitoring processes did not identify areas for improvement as identified through the site audit. Staff were operating outside their scope of practice and reported being unable to properly attend to consumers with the implementation of a new household model of care. Consumers were subject to restrictive practices without proper assessment, consent or ongoing evaluation of the impact of such restraints on their physical and social wellbeing. Existing organisational governance systems did not identify and/or did not address this deficits. While the service has identified appropriate governance improvements to address the issues outlined, steps taken after site audit cannot demonstrate compliance. Based on the evidence and reasoning outlined above, I find the service is not compliance with Requirement 8(3)(c).

**Requirement 8(3)(d)**

The Assessment Team found the service did not demonstrate consumers living with dementia each had their high impact and high prevalence risks associated with care managed effectively, including weight loss, pain, behaviours, falls. Some consumers’ clinical documentation, including incident reports, progress notes, assessments and care plans demonstrated the service was not consistently or accurately assessing consumers’ high impact risks, including pain, weight loss, falls, behaviours and wounds and pressure injuries following changes or ongoing incidents. When strategies in the care plans were not effective, new strategies to manage the risks were not implemented to reduce or prevent further incidents or impacts to the consumer. Staff were not aware of current strategies to manage consumers’ known risks, did not know what behaviour support plans were or where they were located and did not have clear understanding of effective behavioural support strategies to trial before resort to chemical restraints. Finally, staff and management were not able to identify consumers with high impact, high prevalence risks and the service’s high-risk register was incomplete. Requirement 3(3)(b) addresses deficits in more detail, and deficits in incident reporting have been outlined earlier in this Standard.

The provider’s response of 1 December 2022 acknowledged the deficits identified during site audit. The response and CIP listed several actions already taken, and some planned, to address the deficiencies. These included, but were not limited to, a clinical analysis of the consumer cohort based on Key Risk Areas. The review identified numerous consumers with active significant weight loss, consumers at high risk of falls, consumers with complex behaviours, consumers with active pressure injuries and consumers subject to chemical and environmental restrictive practices. Appropriate assessment and monitoring, as well as referral pathways for those consumers were identified and the service’s risk register updated. Staff meetings for the remainder of the year were scheduled and a review of the service-level clinical governance processes had been completed. The response also outlined the various measures already in place to support effective clinical governance and risk management. The response gave an assurance management would receive training on incident reporting and investigation.

I acknowledge the service has identified several appropriate actions to address the deficits outlined in the report. However, at the time of the site audit the service did not have an effective risk management system. Staff practice was not in line with risk management procedures in relation to incidents, management of high risks, recognising restrictive practices and supporting consumers to live the best life they can. The organisation’s and the service’s own monitoring systems did not identify the deficits. Numerous shifts in practice, supported by thorough training, will be required to improve the service’s performance in high prevalence, high impact risk areas such as wound and skin care, behaviour management, dignity of risk and incident management and reporting. Based on the evidence and reasoning outlined above, I find the service is not compliant with Requirement 8(3)(d).

**Requirement 8(3)(e)**

The Assessment Team found the service had policies and procedures in place to ensure staff adhered to antimicrobial stewardship principles and infection prevention and management principles. However, some staff were not conversant in principles of antimicrobial stewardship. The Assessment Team also found minimal evidence the service practiced open disclosure when things went wrong, as discussed previously in assessment of the service’s performance against Requirement 6(3)(c).

The provider’s response of 1 December 2022 acknowledged the deficits identified during site audit. The response and CIP listed several actions already taken, and some planned, to address the deficiencies, including reinforcing existing governance systems and process to improve clinical monitoring, as already outlined. Additionally, the CIP showed management had commenced review of infection reports and the pharmacy antimicrobial reports, to be completed monthly.

I acknowledge the service has identified relevant improvements to address the issues identified by the Assessment Team. However, at the time of site audit, the service did not have effective clinical governance, safety and quality systems in place to maintain and improve the reliability, safety and quality of clinical care, particularly in relation to open disclosure and minimising the use of restraints. Restraints were used without evidence they were necessary, contrary to legislation and the organisation’s own policies. Incident reporting and complaint handling was deficient and consumers said the service did not apologise when things went wrong. Staff were not aware of principles of antimicrobial stewardship, with minimal evidence available to show the clinical governance framework extended to monitoring of infection and antibiotic usage at the service level. Based on the reasoning and evidence outlined above, I find the service is not compliant with Requirement 8(3)(e).

I am satisfied the remaining Requirement in Quality Standard 8 is compliant.

Documentation review showed consumers were engaged in evaluation of services through ‘resident/relatives’ meeting, the men’s and women’s groups and consumer surveys.

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