Uralba Hostel

Performance Report

50 Tor Street   
GUNDAGAI NSW 2722  
Phone number: 02 6944 2066

**Commission ID:** 0285

**Provider name:** Gundagai and District Hostel Accommodation Inc

**Site Audit date:** 1 February 2022 to 3 February 2022

**Date of Performance Report:** 20 April 2022

# Performance report prepared by

Dee Kemsley, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 18 March 2022.
* the service’s compliance history.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific requirements have been assessed as Compliant.

The Site Audit Report identified that consumers considered that they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they chose. Consumers said they felt respected and that their identity and diversity was valued; staff respected their backgrounds, values and beliefs. Consumers described how they were supported to exercise choice, maintain relationships and their independence. Consumers were supported to take risks and live the best life they could and consumers and representatives reported how they received information to make decisions; this included through monthly newsletters, the service keeping in regular contact with them and staff explaining any personal or clinical procedures to consumers before undertaking them. Consumers noted that they felt their personal privacy was respected.

Management said each consumer's culture and diversity needs and preferences were identified on entry; this information was incorporated into the consumer’s care and lifestyle program. Staff advised of the importance of understanding the culture and diversity needs of consumers, including their religious preferences, ensuring consumers’ care and services were delivered in a culturally safe way. Consumers were supported to make informed choices through communication with staff and the provision of options. Staff assisted consumers to maintain relationships, and to stay in contact with family and friends during COVID-19 visitor restrictions; this included using digital devices for messaging and video calls. Consumers were supported to participate in risk-taking activities of their choice with staff assisting consumers to understand potential risks and staff described strategies implemented to manage or minimise the risks. Information was provided to consumers in line with their communication needs and preferences. Staff spoke of the practical ways that they respected the personal privacy of consumers.

Care planning documentation reflected the diversity of consumers at the service, including consumers’ life experiences, events and backgrounds. Documentation identified consumers cultural backgrounds, related needs, preferences, and demonstrated consumers made decisions about when representatives should be involved in their care. Care documentation described areas consumers were supported to take risks and live the life they chose; this generally included completed risk assessments and strategies implemented to mitigate or manage the risks identified. I have considered the completion of consumers’ assessments related to risk more broadly under Requirement 2(3)(a).

The service had policies and procedures that addressed how staff were to treat consumers with respect and dignity, value their diversity and identity; and to support consumers to exercise choice, make decisions about their care and the way services were delivered. A monthly activities calendar and a daily menu board was displayed in the service environment. Consumers’ personal information was observed to be confidentially and securely maintained. Staff interactions with consumers were observed to be friendly, polite and respectful. Consumers were observed spending time and participating in activities together and engaged in conversations in communal areas.

Based on the evidence summarised above, I find the service to be Compliant with Standard 1; Consumer dignity and choice.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

### Requirement 1(3)(d) Compliant

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

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

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

### Requirement 1(3)(f) Compliant

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Site Audit report identified the Assessment Team had recommended Requirement 2(3)(a) was compliant. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and I have come to a different view. I find the service non-compliant with Requirement 2(3)(a) and I have provided reasons for my findings in the specific Requirement below.

The Site Audit report reflected that overall consumers considered that they felt like partners in the ongoing assessment and planning of their care and services. Consumers said they were confident that staff provided them with the care they needed. Consumers and representatives reported staff involved consumers in the assessment and care planning process both on entry and on an ongoing basis. Consumers and representatives were aware of consumers’ care planning documentation, how to access it, and said care and services provided were reviewed regularly and when changes occurred.

Care planning documentation demonstrated that through assessment and planning, the service generally considers risk to the consumer’s health and wellbeing. The service generally evidenced that assessment and planning informed the delivery effective care and services and in line with its policies and procedures. However, for two named consumers, the service was not able to demonstrate that consideration of risks to the consumer’s health and well-being were consistently assessed, and/or that the consumer’s care plans were then adequately updated. Consumers’ documentation detailed their individual needs and preferences, and reflected consumers and representative were involved in the assessment, planning and review processes. Care plans were available to the consumer on request and reflected others were involved in care planning such as the medical officer and allied health professionals. Changes to consumers’ care documentation was communicated to their representatives, and care plans demonstrated regular review occurred, including when incidents or changes occurred.

Management and staff advised of assessments consumers completed on entry, which informed the development of the consumers’ care planning documentation; these assessments were reviewed three monthly or when there was a change in the consumer’s condition. The service was a low care facility and when consumers experienced a marked deterioration they were transferred to a higher care facility; consumers were notified of this on entry and the service supported consumers during the process. Staff discussed end of life planning with consumers and representatives on entry, and palliative assessments were conducted between the consumer and medical officer. Staff described processes for referral to allied health professionals and ensured changes made by external professionals was appropriately communicated to the staff. The outcomes of assessments and care planning were documented and communicated to consumers and representatives.

The service had policies and procedures regarding consumer assessment, reassessment and care planning, including advanced care directive process, and the ongoing basis for review of consumers’ risk, needs, goals and preference changes. The service monitored and trended consumers’ clinical indicators and documentation evidenced representatives were contacted following incidents. The community nurse was observed to attend to the review of two consumers’ wounds.

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

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

The Assessment Team recommended that this Requirement was compliant. The Site Audit report reflected that the service demonstrated consumers’ assessment and planning generally informed the delivery of effective care and services. Care planning documentation contained initial and ongoing assessments, which were reviewed every three months; for skin integrity, pain management, mobility and falls risk, nutrition and hydration, vision and hearing, oral and dental care, behaviour charting and palliative care.

However, for two named consumers, the service was not able to consistently demonstrate that consideration of risks to these consumers’ health and well-being had been appropriately assessed and/or the consumers’ care plans updated to reflect the risks, or that strategies to manage or minimise the risks had been implemented. For one consumer, while a medical officer had assessed the consumer prior to prescribing psychotropic medication (chemical restraint), the service was not aware of the consumer’s changed care needs or the potential risks associated with the administration of a chemical restraint. The consumers care plan did not document that consent for the chemical restraint had been obtained, or management strategies implemented to guide staff practice in relation to the restrictive practices; including monitoring and review process to evaluate the effectiveness of the intervention.

The Approved Provider in its written response to the Site Audit findings said the service had not been aware of the outcome of an external medical appointment where the chemical restraint had been prescribed for the consumer. However, the consumer’s representative had attended the appointment and was aware of the prescription. While the service subsequently became aware of a change in the consumer’s medication, the service did not have access to the medical officer’s notes to understand the reason for the change in medication. I have considered this aspect more broadly under Requirement 3(3)(a). The provider said the consumer’s care plan had been amended the day following the completion of the audit; to safely manage the use of a chemical restraint, to ensure the correct interventions were being adhered to by staff and to ensure the effectiveness of the restraint was being monitored. The provider also reported the consumer’s care plan had been further amended in March 2022 as the use of the chemical restraint had been ceased.

The Site Audit report identified that for another consumer, the service did not conduct an assessment in relation to the consumer’s participation in a risk taking activity of their choice. In its response, the provider advised and documentation submitted demonstrated, in consultation with the consumer an assessment has now been completed in awareness of the consumer’s wish to participate in a risk taking activity. The consumer has signed the risk assessment and their reviewed care plan, which has been amended to incorporate the identified risks and management strategies in relation to the activity.

In this Requirement the Site Audit report identified there were no registered clinical staff, including registered or enrolled nurses, rostered within the service at any point. Management explained how the service was physically internally linked to the local hospital, could access local medical officers and other health professionals, and that care staff were specifically trained and maintained competencies in medical administration, with the support of procedural documentation, to assist the completion consumer assessments. I have further considered this aspect further under Requirements 3(3)(a) and 8(3)(e).

In coming to a decision on compliance for this Requirement, I have considered the response from the Approved Provider and information contained in the Site audit report, under this and other Quality Standards, including Standards 3, 7 and 8. While I acknowledge the actions completed and that are being taken by the provider to address the deficiencies identified, I remain of the view that at the time of the audit assessment and planning did not always consider the risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services.

For the reasons detailed above, I find the service to be Non-Compliant.

### Requirement 2(3)(b) Compliant

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

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

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

### Requirement 2(3)(d) Compliant

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

### Requirement 2(3)(e) Compliant

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Site Audit report identified the Assessment Team recommended that Requirement 3(3)(a) was non-compliant. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and I find the service Non-compliant with Requirement 3(3)(a). I have provided reasons for my findings in the specific Requirement below.

The Site Audit report reflected that overall consumers considered that they received personal care and clinical care that was safe and right for them. Consumers advised in a variety of ways that their care needs were being well managed and consumers were comfortable and felt safe with the care provided by staff. Consumers said staff had discussed their advanced care directives or end of life wishes, and consumers’ were aware of the service’s process in relation to end of life care. Consumers and representatives reported they were satisfied with the quality of care provided and how the service responded to the changing needs of consumers; consumers had access to medical officers and other relevant health professionals when they needed it. Consumers expressed their satisfaction with how management had responded to the recent COVID-19 outbreak, the level of communication received; said staff washed and sanitised their hands before and after consumer interactions, when assisting around the service, and at mealtimes. Staff wore personal protective equipment at all times.

Consumers’ care planning documentation reflected consumers generally received individualised care that was tailored to their needs and preferences; key risks were generally identified and managed appropriately, including pain management, skin integrity including pressure injuries, management of falls, behaviour management, nutrition and hydration cares and infection requirements. However, the service was not able to consistently demonstrate that personal or clinical care provided to consumers was best practice, optimised the consumer’s health and well-being; this was specifically in relation to managing and minimising the use of restraint.

Care documentation generally identified strategies were implemented to manage key risks to consumers and detailed consumers’ advanced care planning information. The service was a low care facility and consumers who experienced significant deteriorated were transferred to a higher care facility or hospital. Documentation demonstrated identification and response to deterioration or changes in the consumers’ care needs and provided adequate information to support sharing of the consumer’s condition. Care documentation evidenced referrals were made to medical officers and allied health professionals; recommendations following referrals were recorded.

Staff said they knew consumers well and if staff were concerned about consumers’ care, this was escalated to management who were onsite or on call. Management advised care was provided with the support of the community nurse, medical officer, allied health professional or ambulance services when required. Staff followed the service’s policies and procedures to ensure effective care was provided and staff reported they attend regular education sessions to update their knowledge and skills. Staff were generally knowledgeable about high impact or prevalence risks and described processes of escalation of care for consumers who experience a deterioration, including observations undertaken and calling for an ambulance when required. Staff described how daily staff handover and diary reports communicated information about consumers’ conditions and changed needs.

Management confirmed consumers referrals to required health professionals were made in consultation with consumers, representatives, health professionals and their medical officer. Management sought pathology reports prior to antibiotics being prescribed by the medical officer and staff described how infection related risks were minimised, including the use of personal protective equipment and good hand hygiene practice; staff have received education and training in relation to infection control and COVID-19 precautions. The service had clinical care policies to guide staff practice that included a risk management framework and clinical incidents were documented and reviewed by management weekly; clinical indicators were discussed in the monthly staff and board meetings. The service has a ‘personal care and clinical care’ policy that includes a focus on maximising comfort and dignity for consumers.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team recommended this Requirement was not met. The Site Audit report identified care planning documentation for consumers reflected consumers generally received individualised care that was tailored to their needs; key risks were generally identified and managed appropriately, including pain management, skin integrity, falls and behaviour management, nutrition and hydration cares and infection requirements. However, the service was not able to always demonstrate that clinical care provided to consumers was best practice and optimised the consumer’s health and well-being; this was in relation to medication management and, managing and minimising the use of restraint.

While one named consumer was administered regular psychotropic medication (chemical restraint) from the end of 2021, staff were not aware of the consumer’s changed medication/care needs, or the potential risks associated with the administration of a chemical restraint. Although a behaviour support plan had been implemented for the consumer prior to the commencement of the chemical restraint, the plan did not document that consent for the chemical restraint had been obtained, or management strategies implemented to guide staff practice in relation to the restrictive practices; including monitoring and review process to evaluate the effectiveness of the intervention. The consumers’ care documentation demonstrated this had not occurred. As the service did not have registered or enrolled nurses on staff, medication prescribed was administered through prepacked medication packs supplied by the pharmacist. Management weren’t aware of the medication change until the consumer’s updated medication pack were received. Management had known of an external medical appointment for the consumer but not of the intent, and while management had requested the relevant medical notes to incorporate this in to consumer care planning documentation, this was not received.

Management advised as there were no registered or enrolled nurses rostered on site, they outlined how the workforce was enabled to deliver quality care and services. The service coordinated medical officer visits and referred consumers to the community nurse. The service was in a small, rural town, staff knew the consumers well, staff conducted observations when consumers were unwell, and staff would call an ambulance to perform assessments and transfer the consumer to hospital if required. Management were either onsite or on-call to provide advice to staff when caring for a consumer. The service utilised the community intake program to lodge referrals for allied health professionals, and the community nurse attended the service regularly to manage consumers’ clinical cares such as wound care.

The Approved Provider in its written response to the Site Audit findings advised an informed consent form was signed by the consumer, which enabled the service to act on the consumer’s behalf. The use of restrictive practises and consent to use these has now been added as a discussion item to the service’s entry procedures. I have considered this aspect further under Requirement 8(3)(e). The service became aware of a medication change on receipt of the consumer’s prepacked medication pack in December 2021. The service had not been aware that the consumer’s representative’s had requested the medical officer to review the consumer’s behaviour management needs, or the decision to commence psychotropic medication; no relevant documentation regarding the medical consultation and outcome was provided. The service had subsequently requested copies of the medical notes, which were received in March 2022.

The consumer’s representative acknowledged awareness of the commencement of the medication and said they had advised the consumer of the medication at the time of the medical appointment. Once aware, management had notified staff of the start of the consumer’s new medication; however, staff were unaware of the implication of the drug. The provider said and documentation demonstrated, the consumer’s behaviour support plan has been updated the day following the audit to reflect the use of a chemical restraint, and a restrictive practice intervention chart was implement for staff to monitor the effectiveness of the intervention. The consumer’s behaviour support plan was further amended in March 2022 when the chemical restraint was ceased.

In relation to the availability of staff with the right skills to meet consumers’ clinical care needs and access to other providers/organisations to improve consumers’ health and wellbeing, the provider said community care intake service is accessible for community nursing intervention, physiotherapy needs, palliative care needs, occupational therapist needs and other community health service needs that the service does not provide. As the service is a low care facility, it does not have consumers that would require a registered nurse for care. If consumers need high care they are transferred to a higher care facility once reassessed by the appropriate person. The service has a good working relationship with the local medical centre; the service is physically connected to the centre with access to both medical officers and nurses 24 hours a day. Staff at the service know the consumers well due to the relationships built from working closely together; staff are aware of any changes in the consumers’ needs, are trained to notify management of any changes noted, will call emergency services as required, and for non-urgent matter; observations are undertaken, reported to manager who then assesses the consumer and follows the local medical centre’s preferred referral process. Each medical officer has a nominated time each week to visit the service and all consumers are pre-booked for a consultation with their nominated medical officer within a monthly period to ensure continuity of care.

In relation to the service not being aware of the consumer’s medication changes in a timely way, and not having access to the medical officer’s notes to understand the reason for the change in the consumer’s medication, the provider said the pharmacy currently supplies a list to local medical centre on a Monday, of prescriptions falling due in the next two week period for consumers. Each consumer will have had a recent and an upcoming appointment with their doctor, who write ongoing prescriptions as requested by the pharmacy.

In respect of this Requirement, the Site Audit report identified gaps in staff knowledge regarding restrictive practices and what was classified as restraint. I have considered this more broadly under Requirement 7(3)(d). The service’s policies and procedures on minimising the use of restraint included psychotropic medication and chemical restraint only. I have considered this further under Requirement 8(3)(e).

In coming to a decision on compliance for this Requirement, I have considered the response from the Approved Provider and information contained in the Site audit report, under this and other Quality Standards, including Standards 2, 7 and 8. While I acknowledge the actions completed and that are being taken by the provider to attend to the deficiencies identified, I remain of the view that at the time of the audit each consumer was not consistently getting safe and effective clinical care that was best practice, tailored to their needs or optimised their health and well-being.

While the service has advised of the close relationship it maintains with the local medical centre, the service has not addressed how it will routinely accesses appropriately skilled individuals to contribute to the effective assessment, planning, managing, monitoring and reviewing of consumers’ clinical needs on a regular basis. There is an expectation that appropriately skilled members of the workforce have responsibility for the provision of effective clinical oversight at the service, to ensure the management and monitoring of consumers’ clinical care they provide is best practice, and supports the efficient implementation of service’s clinical governance framework. The service has also not addressed how it will improve timely communication of medical officer’s directives and outcomes, following the medical officer’s review of consumers.

For the reasons detailed above, I find the service to be Non-Compliant.

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

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

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

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

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

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

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

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

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

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

### Requirement 3(3)(g) Compliant

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

The Site Audit report identified that overall consumers considered that they got the services and supports for daily living that were important for their health and well-being and that enabled them to do the things they wanted to do. Consumers said staff were aware of their individual needs and preferences and they were supported to do things they wanted to optimise their independence and wellbeing. Consumers felt supported when they were feeling low and had access to supports and services to meet their emotional and psychological needs. Consumers advised they were supported to keep in touch with the people who were important to them and do things of interest to them within and outside the service. Consumers and representatives described how staff engaged with individuals and organisations outside the service to support consumers daily living needs; this included hairdresser and beautician services, and volunteers of religious denominations to provide services. Consumers provided positive feedback about the food and expressed their satisfaction with the quality, quantity and variety of meals.

Care planning documentation included information about the services and supports consumers needed to do the things they wanted to. Documentation identified the background and life history of consumers, their interests, preferences, likes/dislikes and capabilities. Consumers’ documentation reflected their spiritual beliefs and emotional support strategies and demonstrated how consumers participated in the community, maintained relationships and did things of interest to them. Care planning provided adequate information to support effective sharing of the consumer’s care; documentation incorporated consumers’ social needs and preferences, dietary needs and preferences and the involvement of others in provision of lifestyle supports.

Staff understood what was important to consumers including how staff were to support consumers’ to promote their independence and quality of life. Management said assessments and regular consumer meetings, enabled consumers to provide input into the lifestyle program; the activities schedule was developed monthly and was based on the ongoing feedback gathered from consumers. Staff described supporting consumers who felt low and assisting consumers with their spiritual beliefs; emotional support and mental health specialists were available for consumers if required. Consumers were supported by staff to participate in the community, keep in contact with the people and do things of interest to them. Staff were kept informed of changes in consumers’ conditions or needs through daily handover meetings; staff worked with external organisations and volunteers to help supplement the lifestyle activities offered. Kitchen staff demonstrated how consumers’ dietary needs were documented to reflect meal size, likes, dislikes, allergies and dietary requirements. Staff reported equipment was regularly cleaned, readily available and detailed the processes undertaken when maintenance/repairs were needed.

The lifestyle program incorporated activities to meet the needs of varying cognitive and functional abilities. Staff were observed encouraging, assisting and supporting consumers during activities and the dining room was observed to be quiet and calm during mealtimes, and staff assisting consumers were polite and respectful. Equipment used to provide and support lifestyle services was observed to be safe, suitable, clean and well maintained.

Based on the evidence summarised above, I find the service to be Compliant with Standard 4; Services and supports for daily living.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

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

### Requirement 4(3)(b) Compliant

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

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

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

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

### Requirement 4(3)(d) Compliant

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

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

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

### Requirement 4(3)(f) Compliant

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

### Requirement 4(3)(g) Compliant

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

The Site Audit report identified that overall consumers considered that they felt they belonged in the service and felt safe and comfortable in the service environment. Consumers and representatives reported they were happy with the service environment and felt at home. Consumers said they found the service environment to be safe, clean and well maintained, and advised they can go outside into the garden and outdoor seating areas freely. Consumers said they felt the furniture, fittings and equipment in the service was safe, clean, well maintained and suitable for them.

Management described how the service environment was welcoming and optimised the consumers’ interactions and functions. This included pictures and signs displayed in areas of the service so the environment was easy to understand for consumers; such as room numbers, bathroom and laundry signs, and name placemats on dining room tables. Hand rails were available throughout the service, corridors were kept clear to prevent hazards, noise was kept to a minimum and mobility assessments were completed to determine the appropriate mobility aids to maximise the support provided for consumers’ independence and function. Management noted consumer bathrooms were being renovated; however, works had to be put on hold due to the recent COVID-19 outbreak.

Staff described the service’s maintenance and cleaning processes and procedures; the service environment is managed by management and staff for smaller works and contractors for larger works. Staff were aware of the process for documenting and reporting safety and maintenance issues once identified. Cleaning staff described their weekly cleaning schedule and staff were able to describe how shared equipment used for transferring consumers was kept safe and clean.

The service environment was observed to be welcoming; with a communal dining room, lounge area and a library/activities room for consumers to congregate and interact with one another. Garden and shaded outdoor seating areas were available at the front and back of the service and each consumer had a porch outside their room, with plants and seating areas available creating a home-like environment. Consumers’ rooms were personalised with artwork, photographs and furniture and consumers were observed moving freely through the service, both indoors and out. Fire evacuation diagrams and illuminated emergency exit signs were displayed throughout the service with fire safety equipment readily available for staff. Consumers had access to and were observed using a range of mobility assistive equipment, which was clean and well maintained.

The service’s preventative maintenance schedule and records demonstrated routine maintenance and servicing of equipment, furniture and fittings. Maintenance logs evidenced issues identified were dealt with promptly and in timely manner. The service’s cleaning schedule identified consumers’ personal mobility aids were cleaned on a daily basis with disinfectant.

Based on the evidence summarised above, I find the service to be Compliant with Standard 5; Organisation’s service environment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

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

### Requirement 5(3)(b) Compliant

*The service environment:*

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

### Requirement 5(3)(c) Compliant

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

The Quality Standard is assessed as Compliant as four of the four specific requirements have been assessed as Compliant.

The Site Audit report identified the Assessment Team had recommended Requirement 6(3)(d) was non-compliant. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and have come to a different view. I find the service compliant with Requirements 6(3)(d) and I have provided reasons for my findings in the specific Requirement below.

The Site Audit report reflected that consumers considered that they were encouraged and supported to give feedback and make complaints, and that appropriate action was taken. Consumers described what they did when they had concerns and said that they were confident that action would be taken in response to feedback and complaints. Consumers explained how they could make a complaint, if they were uncomfortable raising concerns with the service directly; this included using external mechanisms and advocacy services. Consumers advised action was taken in response to complaints, an open disclosure process was followed and the service had made changes as a result of feedback.

Staff said consumers were supported and encouraged to provide feedback and raise complaints, and described how they responded to consumers if they raised an issue or concern; including assisting consumers to complete a feedback form which was provided to management for further action. Staff described the advocacy services available to consumers and how they sought feedback from consumers who had difficulty communicating. Management advised whilst no consumers required interpreter services, measures and supports were in place to ensure consumers were supported if required. Staff explained actions taken in relation to consumer feedback and complaints, and management and staff were knowledgeable of the open disclosure process and how it related to complaints, including notifying the consumer and their representatives and apologising when things went wrong.

However, the service was not able to adequately demonstrate that informal and verbal feedback and complaints were recorded in feedback and complaints logs, reviewed for the effectiveness of the service’s response to a raised issue, and analysed to identify trends and themes which were then used to improve the quality of care and services. Whilst the service’s policies and procedures reflected that insights from the review of feedback and complaints were to be provided to staff and the board, the service’s meeting minutes did not demonstrate this.

Procedures for complaints and feedback resolution were displayed in the reception area of the service, were accompanied with feedback and complaint forms, and a suggestion box for consumers and representatives to use. The service had policies and procedures describing the way consumers were encouraged to provide feedback and raise complaints, and how feedback was valued and used to improve the care and services delivered to consumers. The consumer handbook detailed internal and external feedback and complaints mechanisms available to them, and advocacy services information was displayed throughout the service. The service had an open disclosure policy identifying the processes to be followed when managing complaints. Meeting minutes demonstrated consumers provided feedback and raised issues or concerns. A complaints register was maintained and included the source of the complaint, the action taken and the outcome achieved.

Based on the evidence summarised above, I find the service to be Compliant with Standard 6; Feedback and complaints.

## Assessment of Standard 6 Requirements

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

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

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

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

### Requirement 6(3)(c) Compliant

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

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

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

The Assessment Team recommended this Requirement was not compliant. The Site Audit report identified that if a consumer raised an issue or concern with management or staff, consumers were asked whether the complaint was to be documented (in the service’s complaints file) or written on a feedback form. Where consumers wanted to raise the concern verbally, management advised the issue was addressed immediately. However, management was not able to demonstrate how feedback and concerns raised verbally and informally, were captured in writing, reviewed for effectiveness of response, and monitored for trends or key themes for inclusion in the service’s continuous improvement plan as required. Informal and verbal feedback was not captured and recorded in the services feedback and complaints logs.

The Approved Provider in its written response to the Site Audit findings said each consumer is asked for any complaints, concerns, and issues at the monthly consumer meeting. All feedback is acted on promptly and in a suitable time frame. All complaints, concerns, and issues are presented at the monthly board meetings. However, in response to the feedback, the provider advised and documentation submitted demonstrated, an informal and verbal feedback form has now been introduced for staff to record all verbal complaints and feedback provided by consumers, family members and staff. This form will be reviewed daily, and all information will be compiled and used for continuous improvement activities. The new verbal log is to be signed off by the board at Board meetings.

The Site Audit report reflected management had said the service’s complaints register was reviewed weekly to identify any areas where the delivery of care and services could be improved. Where an issue or improvement area was identified, it was communicated at the monthly staff and board meetings, demonstrating a whole-of-service approach in improving the quality of care and services. Management had advised a complaint made by a named consumer was used to improve care and services for the other consumers at the service. However, staff and board meeting minutes did not demonstrate that insights from feedback and complaints were delivered and discussed to ensure a continuous improvement approach.

In its response the provider submitted additional and clarifying information through supporting documents, including meeting minutes and complaints data, and advised that at the time of the audit, management had been unable to locate the corresponding Board meeting minutes regarding the formal complaint of the consumer. The additional information provided demonstrated the complaint (in relation to unprofessional and unkind behaviour of a staff member) had been addressed by management to the satisfaction of the complainant, all staff had been notified of the nature of the complaint at a staff meeting; and the complaint was raised, documented and actioned as part of the Board’s meeting minutes.

In coming to a decision on compliance for this Requirement, I have considered the response from the Approved Provider and information contained in the Site audit report, under this and other Quality Standards, including Standard 1, 7 and 8. I have noted that in the Site Audit report consumers described how the service had made changes as a result of feedback; particularly in relation to menu changes. Consumers, including the named consumer, said staff treated consumers well and were respectful and gentle when providing care. Consumer meeting minutes from 18 January 2022 demonstrated consumer feedback was sought and actioned; this included rearranging furniture to a consumer’s satisfaction. The service’s continuous improvement logs demonstrated that issues were identified following consumer feedback, planned actions were taken, and outcomes were achieved; this included the service purchasing a smart TV and subscribing to a film and television streaming service, which consumers had said they enjoyed.

Based on the Site Audit report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of non-compliance and find the service compliant with this Requirement. I acknowledge the service has now introduced an informal and verbal feedback form to record all verbal complaints and feedback; and has established processes to ensure this information is to be considered as part of the service’s continuous improvement activities. I further acknowledge that additional information submitted by the provider demonstrates that feedback and complaints are tabled and discussed at Board meetings, to ensure a continuous improvement approach. I have also given weight to feedback and information reflected in the Site Audit report that evidences the organisation had made changes at the service as a result of feedback, to the satisfaction of consumers.

For the reasons detailed above, I find the service to be Compliant with this Requirement.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Site Audit report identified the Assessment Team recommended that Requirement 7(3)(d) was non-compliant. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and I find the service Non-compliant with Requirement 7(3)(d). I have provided reasons for my findings in the specific Requirement below.

The Site Audit report reflected that overall consumers considered that they got quality care and services when they needed them and from people who were knowledgeable, capable and caring. Consumers and representatives expressed satisfaction with the care and services consumers received and advised there were enough staff at the service. Consumers provided feedback that staff engaged with them in a kind, caring and respectful manner and staff knew what they are doing. Consumers and representatives said they felt confident that staff were suitably skilled to meet the consumers’ care needs.

Management advised there were no registered or enrolled nurses rostered on site, and they outlined how the workforce was enabled to deliver quality care and services. I have considered this aspect more broadly under Requirements 3(3)(a) and 8(3)(e). Staff reported staffing levels were sufficient to respond to consumers requests for assistance; management said shifts were filled and service did not use agency staff. Staff felt supported by management to provide the appropriate level of care consumers’ needed, and management were on-call afterhours and during the overnight shift; shifts were replaced in the event staff required unplanned leave. Management described processes implemented to ensure staff were competent and capable in their role, which included orientation and onboarding for new staff, a buddying system with experienced staff, an annual performance appraisal procedure and delivering training with the aim for knowledge to be transformed into the care practice. Management advised regular theoretical and practical competency assessments were performed for all staff.

The service’s staff roster demonstrated staff on leave had their shifts re-allocated, rostered duties were assigned and outlined specific duties to be conducted. Staff performance appraisals were conducted annually or as needed, and the service had documented competencies for various staff roles; documentation demonstrated that staff competency assessments were performed on a regular basis and had been completed. Training policies and procedures incorporated mandatory training requirements to be completed by staff on a regular basis; however, this training does not include minimising the use of restraint and behaviour support plans. The service was also unable to demonstrate that training had been conducted in relation to minimising the use of restraint and the requirement for behaviour support plans; staff were unable to explain the requirements of restrictive practices.

Staff interactions with consumers was observed to be kind, caring and respectful. When administering medication staff were observed being respectful of consumers’ privacy; staff knocked on consumers’ doors, asked permission prior to entering their rooms and addressed consumers by their preferred name. Staff observations demonstrated staff had a shared understanding of their roles and responsibilities.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

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

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

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

### Requirement 7(3)(c) Compliant

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

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

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

The Assessment Team recommended that this Requirement was non-compliant. The Site Audit report identified consumers and representatives were confident in the abilities of staff delivering care and services, said staff knew what they were doing and they could not think of any additional training staff required. Staff advised they were satisfied with the training provided by the service and reported staff undertook mandatory training in workplace health and safety, manual handling, chemicals, compulsory reporting, bullying and harassment, handwashing, infection control and prevention, clinical care and fire safety. Staff also advised they were able to request access to any further training they might require.

However, the service was not able to demonstrate that the workforce was trained and equipped to carry out their roles and responsibilities following the changes to the Quality Standards in relation to minimising the use of restrictive practices, including information required in relation to consumers’ behaviour support plan. Staff could not recall whether they had undertaken training on the legislated changes made to restrictive practices, including minimising the use of restraint for consumers and understanding what a behaviour support plan was. Mandatory training was outlined in the service’s policies and procedures; however, this training did not include minimising the use of restraint and behaviour support plans. Information provided by management and training records did not demonstrate that training around changes to restrictive practices had been provided. While the service had conducted mandatory serious incident response scheme training, staff were not aware of the serious incident response scheme reporting requirements.

In its written response to the Site Audit findings the Approved Provider advised that due to staff retirement, the service had experienced a large turn over in staff that had influenced staff knowledge as new staff are still learning; COVID 19 restrictions had also impacted training sessions. The provider reported and documentation submitted demonstrated, all staff had received education on the changes to the Quality Standard and serious incident response scheme training; this education was provided online via the Aged Care Quality and Safety Commission learning portal and has now been added to the service’s mandatory education. Management has also purchased an online serious incident response scheme module for staff to complete yearly. To ensure staff are well educated and informed on how to report an incident, staff will also be required to complete a serious incident response scheme quiz.

The provider said behaviour support plan education had been presented at a staff meeting held in November 2021. Staff completed education on key concepts of minimising the use of restraint in residential aged care and this education will be added to the service’s mandatory education. The service is currently resourcing more online education to assist with the service’s training and education goals; this included a recognising restrictive practices workshop, and behavioural care plans. Training for the new restraint requirements will be attended to as soon as possible.

In coming to a decision on compliance for this Requirement, I have considered the response from the Approved Provider and information contained in the Site audit report, under this and other Quality Standards, including Standards 2, 3, and 8. While I acknowledge the actions completed and that are being taken by the provider to address the deficiencies identified, I remain of the view that at the time of the audit the workforce was not appropriately trained, equipped and supported to deliver the outcomes required by these standards. This is relation to the changed legislative requirements relating to the use of restrictive practices in particular and the shared understanding of staff of their roles and responsibilities regarding the serious incident response scheme.

For the reasons detailed above, I find the service to be Non-Compliant with this Requirement.

### Requirement 7(3)(e) Compliant

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Site Audit report identified the Assessment Team recommended that Requirements 8(3)(c and 8(3)(e) were non-compliant. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and I have come to a different view. I find the service Compliant with Requirement 8(3)(c) and Non-compliant with 8(3)(e). I have provided reasons for my findings in the specific Requirements below.

The Site Audit report reflected that overall consumers considered that the organisation was well run and that they could partner in improving the delivery of care and services. Consumers and representatives said in various ways that they were confident the service was well run, and they were satisfied with the level of their engagement in the development, delivery and evaluation of care and services.

Management and staff described ways consumers were encouraged to be involved in decisions about changes to the service the delivery of care and services. This included via monthly consumer meetings, complaints and feedback mechanisms, discussions through management’s open door policy and consumer satisfaction surveys. The service demonstrated the organisation’s governing body (Board) generally promoted a culture of safe, inclusive and quality care through the provision of approved policies and procedures in relation to each Quality Standard; the Board was kept informed of the Standards and legislative requirement changes. However, the organisational governance policy did not include the serious incident response scheme reporting obligations, or how incidents were reported. Although staff confirmed serious incident response scheme training had been provided, staff were unable to demonstrate their knowledge regarding serious incident response scheme reporting requirements.

While the service demonstrated it generally had effective organisation wide governance systems in place, the service could not adequality show organisation wide governance in relation to regulatory compliance. Legislative changes around restrictive practices had not been effectively communicated to staff and staff were unable to describe, or demonstrate the implementation of, practical elements of the changes. The organisation had a documented risk management framework that incorporated management of consumers’ high impact or high prevalence risks, identification and response to the abuse and neglect of consumers, and consumers being supported to live the best life they could.

The service had a clinical governance framework that included antimicrobial stewardship, open disclosure and minimising the use of restraint. However, the policy regarding minimising the use of restraint was not comprehensive; it detailed psychotropic medication and chemical restraint only as restrictive practice and did not include information regarding what is to be included in a consumers’ behaviour support plan. Staff did not have a shared understanding of what was required in relation to consumers’ behaviour support plans, or the legislated changes regarding restrictive practices.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

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

### Requirement 8(3)(b) Compliant

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

### Requirement 8(3)(c) Compliant

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

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

The Assessment Team recommended that this Requirement was non-compliant. The Site Audit report identified the service had effective organisation wide governance systems in place in relation to information management, continuous improvement and financial governance. However, the service was not able to adequately demonstrate the organisation wide governance systems relating to regulatory compliance, workforce governance or feedback and complaints were effective.

In relation to regulatory compliance, the service monitored changes to legislative requirements through correspondence received from external agencies, regulatory bodies and was a member of an aged care peak body. Changes to legislative requirements were generally disseminated to staff through staff meetings, memorandums, email correspondence, staff education and training sessions. However, staff did not have a shared understanding of legislative changes around restrictive practices and for one consumer subject to chemical restraint, the consumer’s care documentation did not document that consent for the chemical restraint had been obtained, or management strategies implemented to guide staff practice in relation to the restrictive practices; including monitoring and review process to evaluate the effectiveness of the intervention. In relation to restrictive practices, the organisational policy and procedure only reflected guidance regarding chemical restraint.

In relation to workforce governance, consumers and representatives were confident in the abilities of staff delivering care and services, said staff knew what they were doing. Staff advised they were satisfied with the training provided by the service and reported staff undertook mandatory training and were able to request access to any further training they might require. However, the service was not able to adequately demonstrate that the workforce was trained and equipped to carry out their roles and responsibilities following the legislative changes to the Quality Standards in relation to minimising the use of restraint. While the service had conducted mandatory serious incident response scheme training, feedback from staff indicated that they were unclear of the serious incident response scheme reporting requirements. The policy and procedure regarding organisational governance did not outline the serious incident response scheme reporting requirements.

In relation to complaints and feedback, the service was not able to demonstrate that informal and verbal feedback and complaints were recorded in the feedback and complaints logs, reviewed for the effectiveness of the service’s response to a raised issue, and analysed to identify trends and themes which are used to improve the quality of care and services.

In its written response to the Site Audit report findings the Approved Provider advised all staff are updated on all legislative changes by the services through daily emails and the service’s update folder; staff are required to read current correspondence and must sign the staff compliance register. Staff further receive updates at staff meetings and are provided with education based on any current changes to any legislative. The Board is updated regarding any changes to legislation and the information is also presented at the monthly board meeting. The organisational policies and procedure have been updated to ensure changed legislative requirements regarding restrictive practises have been added; this will be tabled at the service’s Board meeting.

The provider reported that due to staff retiring the service has experienced a large turn over in staff in the past year, which has influenced staff knowledge as new staff are still learning and COVID 19 restrictions had impacted the service’s training program. The provider said and documentation submitted demonstrated, all staff had received education on the changes to the Quality Standard and serious incident response scheme training. The service is currently resourcing more online education to assist with its training and education goals, including to improve staff knowledge in relation to the serious incident response scheme and the reporting requirements relevant to each staff member’s role and responsibilities. The organisational policies and procedure have been updated to ensure serious incident response scheme reporting requirements have been added.

In response to feedback and complaints, the provider said each consumer is asked for any complaint, concern, or issues at the monthly consumer meeting. All feedback is acted on promptly, and complaints, concerns, and issues are presented at the monthly Board meetings; consumer feedback is used for continues improvement.

An informal and verbal feedback form has now been introduced for staff to record verbal complaints and feedback provided by consumers, family members and staff. The form will be reviewed daily, all evidence will be compiled and used for continuous improvement as relevant; new form will be signed off by the Board at their next meeting.

In coming to a decision on compliance for this Requirement, I have considered the response from the Approved Provider and information contained in the Site audit report, under this and other Quality Standards, including Standards 3, 7 and 8. I acknowledge the actions already completed and that are being taken by the provider to address the deficiencies identified. I have placed weight on the overall demonstration that the service had effective organisation wide governance systems in place; and where deficiencies had been identified I have already considered these more broadly under other Requirements, as follows:

* In relation to regulatory compliance, and specifically restrictive practices, I have considered this further under Requirements 3(3)(a), 7(3)(d) and 8(3)(e).
* In relation to workforce governance, and specifically the training requirements of staff to be equipped to carry out their roles and responsibilities following the legislative changes to the Quality Standards in relation to minimising the use of restraint; I have considered this further under Requirement 7(3)(d).
* In relation to complaints and feedback, and specifically in relation to informal and verbal feedback and complaints, I have considered this further under Requirement 6(3)d).

For the reasons detailed above, I find the service to be Compliant with this Requirement.

### Requirement 8(3)(d) Compliant

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

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

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

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

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

The Assessment Team recommended that this Requirement was non-compliant. The Site Audit Report identified the service demonstrated it had a clinical governance framework that included antimicrobial stewardship and open disclosure. Management provided examples of the way that care and services were delivered or evaluated as a result of implementation of the open disclosure policy; including staff being responsible and accountable and management being open and honest in their communications with consumers and representatives. While there was no documented information on the appropriate use of antimicrobial stewardship, management said they sought pathology reports prior to contacting the consumer’s medical officer; antibiotics were only prescribed by the medical officer and administered through prepacked medication packs prepared by the pharmacist.

However, while the clinical governance framework had been updated to include minimising the use of restraint, the update was not comprehensive and did not appropriately reflect the responsibilities of approved providers under the *Aged Care Act 1997*and the *Quality of Care Principals 2014* regarding the use of any restrictive practice in residential aged care, applicable from 1 July 2021. The update did not include information that is required to be included in a consumers’ behavioural support plan, and the service’s policy relating to minimising the use of restrictive practices outlined psychotropic medication and chemical restraint only.

Management were not able to provide examples in relation to minimising the use of restraint and staff were not aware of the legislated changes to restrictive practices or what a behaviour support plan was. For one named consumer, while a medical officer had assessed the consumer prior to prescribing psychotropic medication (chemical restraint), staff were not made aware of the consumer’s changed care needs or the potential risks associated with the administration of a chemical restraint. The consumer’s care plan did not document consent for the chemical restraint, or management strategies to guide staff practice in relation to the restrictive practices; including monitoring and review processes to evaluate the effectiveness of the intervention. The consumers’ care documentation demonstrated this had not occurred.

The Approved Provider in its written response to the Site Audit report findings stated the service’s policy and procedures on minimising the use of restraints incorporated psychotropic medication, chemical and environment restraint. The organisation has now amended its policy in relation to the legislation of the five types of restrictive practices; chemical, physical, mechanical, environmental restraint and seclusion. Policies and procedures have been updated to ensure consumers prescribed and administered a chemical restraint, also have their behaviour support plan updated to reflect restrictive practices are being used and monitored in line with appropriate documentation from their medical officer. Assessment, authorisation and review in relation to restrictive practises must be completed by the consumer’s medical officer, and signed by the consumer and their representative. This policy is to be tabled at the next Board meeting.

The provider advised an informed consent form was signed by the consumer in the presence of their representative, allowing the service to act on the consumer’s behalf. The consent notifies consumers staff may need to assist with administering medications, perform procedures in relation to providing personal and clinical care/interventions care, and discuss the consumer’s care with their medical officer. The informed consent has now been amended to include discussions with the consumer and/or representative regarding the use of restrictive practises, the consent required for these to be used and for the service to be notified.

In coming to a decision on compliance for this Requirement, I have considered the response from the Approved Provider and information contained in the Site audit report, under this and other Quality Standards, including Standards 2, 3 and 7. While I acknowledge the actions already completed and that are being taken by the provider to address the deficiencies identified, I remain of the view that at the time of the audit the service’s clinical governance framework did not adequality address or demonstrate effective processes in relation to the minimising the use of restraint.

For the reasons detailed above, I find the service to be Non-Compliant with this Requirement.

# Areas for improvement

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

* Assessment and planning, including consideration of risk, informs the delivery of safe and effective services.
* Each consumer gets safe and effective clinical care that is best practice, tailored to their needs and optimises their health and wellbeing.
* The workforce is trained, equipped and supported to deliver the outcomes required by these Standards.
* Where clinical governance is provided, the clinical governance framework includes minimising the use of restraint.