Performance

Report

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| Name of service: | Uralba Retirement Village |
| Service address: | 5 Eulamore Street CARCOAR NSW 2791 |
| Commission ID: | 0220 |
| Approved provider: | Burswood Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 6 June 2023 to 8 June 2023 |
| Performance report date: | 4 August 2023 |

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

**This Performance Report**

This Performance Report for Uralba Retirement Village (**the service**) has been prepared by Melissa Buhagiar, 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 6 June to 8 June 2023, 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 3 July 2023
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: Notice to Agree dated 13 June 2023 following Site Audit conducted 6 to 8 June 2023, Assessment Team report following Site Audit conducted 6 to 8 June 2023, Performance report dated 28 October 2022 following Assessment Contact conducted 5 October 2022.
* any relevant information about the approved provider of the Service given to the Commissioner by the Secretary; Exceptional Circumstances Determination dated 27 March 2023 and 26 September 2022

**Assessment summary**

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| Standard 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 | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

**Areas for improvement**

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

Requirement 1(3)(a) The approved provider must demonstrate that staff communicate about consumers in a respectful way and all consumers are treated with dignity and respect, with their identity, culture and diversity valued.

Requirement 1(3)(c) The approved provider must demonstrate that systems are implemented to support consumers to exercise choice and independence and make decisions about who and how they wish others to be involved in their care.

Requirement 1(3)(d) The approved provider must demonstrate risks are identified for activities undertaken by consumers to enable them to live the best life they can and that measures are put in place to mitigate risks related to those actions.

Requirement 1(3)(f) The approved provider must ensure that consumer’s privacy is respected and personal and clinical care is conducted in the consumer’s room.

Requirement 2(3)(a) The approved provider must demonstrate that comprehensive and accurate assessment and planning is undertaken in line with organisational guidelines and in a timely manner to identify risks to the consumer’s health and well-being and to inform the delivery of safe and effective care and services.

Requirement 2(3)(b) The approved provider must demonstrate that case conferences are conducted with consumers and representatives and the consumer’s current needs, goals and preferences are identified, including advance care planning and end of life planning if the consumer wishes.

Requirement 2(3)(c) The approved provider must demonstrate that care planning occurs in partnership with the consumer and representative and others that the consumer wishes to be involved which includes other organisations or providers that the consumer has been referred to.

Requirement 2(3)(d) The approved provider must demonstrate that assessment and planning is undertaken and the outcomes of this are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer and representative.

Requirement 2(3)(e) The approved provider must demonstrate that 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 and that recommendations or directions from providers or medical officers are documented and followed.

Requirement 3(3)(a) The approved provider must demonstrate that staff have training to follow the services’ policies and procedures and that qualified staff are making clinical decisions and care staff do not undertake assessments outside of their scope of practice.

Requirement 3(3)(b) The approved provider must demonstrate that the service identifies high impact/high prevalence risks associated with the care of consumers though review of incidents and that all incidents are documented on incident reports and investigated to develop mitigating strategies to prevent the reoccurrence of incidents.

Requirement 3(3)(c) The approved provider must demonstrate they are recognising and addressing the needs, goals and preferences of consumers nearing the end of life to maximise their comfort and preserve their dignity.

Requirement 3(3)(d) The approved provider must demonstrate changes or deterioration in consumers’ physical health and function and mental health, and that their capacity or condition is recognised and responded to in a timely manner.

Requirement 3(3)(e) The approved provider must demonstrate all consumers' information including assessments and care plans are entered into the electronic system accurately and medical officer notes and providers information is accurately documented and reviewed by staff to ensure that consumers’ condition, needs and preferences are known by staff who need to know.

Requirement 3(3)(f) The approved provider must demonstrate consumers are referred to appropriate medical and specialist services in a timely manner, when their condition changes to improve outcomes for their health and well-being.

Requirement 3(3)(g) The approved provider must demonstrate that staff follow the Department Of Health guidelines in relation to personal protective equipment and infection control and staff undertake training and understand infection prevention and control and antimicrobial stewardship and demonstrate a practical knowledge of this.

Requirement 4(3)(a) The approved provider must demonstrate that Key to Me or equivalent assessments are undertaken to guide staff in providing individually tailored care, services and supports for daily living.

Requirement 4(3)(b) The approved provider must demonstrate assessment and care planning is undertaken to understand consumers’ needs and preferences regarding emotional, spiritual and psychological support and to guide staff in delivering services and support.

Requirement 4(3)(c) The approved provider must demonstrate that comprehensive assessment is undertaken to understand the needs of consumers to provide meaningful service and support for daily living for each consumer.

Requirement 4(3)(d) The approved provider must demonstrate that information about the consumer’s condition, needs and preferences is accurately captured, documented and communicated within the organisation, and with others where responsibility for care is shared and that information provided to consumer and representatives is current.

Requirement 4(3)(e) The approved provider must demonstrate that there are accurate, timely and appropriate referrals to individuals, other organisations and providers of other care and services and that staff are aware of these providers.

Requirement 6(3)(d) The approved provider must demonstrate feedback and complaints is documented and reviewed to improve the quality of services to consumers.

Requirement 7(3)(a) The approved provider must demonstrate the workforce is planned to provide sufficient qualified staff to enable, the delivery and management of safe and quality care and services and that unqualified staff are not working outside of their scope of practice.

Requirement 7(3)(c) The approved provider must demonstrate they provide effective human resource systems and training to ensure the workforce are competent and have a sound knowledge to effectively perform their roles and that all staff are working within their scope of practice.

Requirement 7(3)(d) The approved provider must demonstrate effective systems to ensure the workforce is recruited, trained, equipped and supported to effectively deliver the outcomes required by the Quality Standards. That staff hold the relevant qualifications associated with their work and demonstrate competence in their roles.

Requirement 8(3)(b) The approved provider must demonstrate there is an effective governance framework to identify and manage deficiencies with actions recorded for identified trends or measures to deliver safe, inclusive and quality care and services.

Requirement 8(3)(c) The approved provider must demonstrate that it has effective organisational systems to monitor information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints and that the organisation can demonstrate that its local governance systems feed into and are supported by the overall organisational governance framework and accountability structure.

Requirement 8(3)(d) The approved provider must demonstrate that it has an effective process for risk management which is effectively monitored; including in relation to managing high-impact or high prevalence risks, support for consumers to live the best life they can and managing and preventing incidents. In addition, staff have the knowledge of responding to abuse and neglect and SIRS.

Requirement 8(3)(e) The approved provider must demonstrate that it has effective comprehensive clinical oversight to ensure the effective implementation of clinical policies and procedures and that all staff are familiar with the policies relating to antimicrobial stewardship, minimising restraint and open disclosure and this is practiced at service level.

**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 | 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. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Non-compliant |

**Findings**

The Quality Standard has been assessed as Non-compliant as four of the six specific requirements have been found to be Non-compliant.

The following requirements 1(3)(b) and 1(3)(e) were found to be Compliant.

The Assessment Team interviewed consumers and representatives who generally provided positive feedback in relationship to the care and services delivered. The Registered Nurse advised there were no non-English speaking consumers living at the service and no one identified as Aboriginal or Torres Strait Islander. Many of the consumers were from the local regional community. Consumers received care and services that are culturally safe with their backgrounds taken into consideration with risk assessments conducted to enable consumers to do things that they enjoy including going for long walks where possible and pet therapy. It was however identified that not all of the ‘key to me’ assessments (Key 2 Me assessments), which prompt for key information about consumers such as their life history and current interests were completed. This also resulted in gaps and deficiencies in the consumers’ therapy, leisure and lifestyle care plan because of the way the electronic care planning system works, with assessment information auto-populating to the care plan.

The Assessment Team spoke with consumers, consumer representatives and staff and conducted observations to understand how information was provided to consumers. Management advised that they communicate with consumers and their representatives through multiple mechanisms including their bi-monthly newsletters, communicating verbally, bi-monthly resident meetings and through email/SMS communication. The Assessment Team reviewed the meeting minutes for the February and April 2023 meetings with the next meeting schedule for 27 June 2023 as well as the latest newsletter provided to consumers.

The Assessment Team observed on day one of the Site Audit information was not readily available in the dining room about the menu for the day and activity calendars had not been created for June 2023 to support consumers to make choices. However, it was demonstrated that information is being communicated to consumers and their representatives in other ways to support choice.

The following requirements 1(3)(a), 1(3)(c), 1(3)(d) and 1(3)(f) were found to be Non-compliant.

The Assessment Team found that although staff are kind and caring, there was a significant amount of information indicating that consumers have not been treated with dignity and respect with their identity, culture and diversity valued. A review of the care and services records for consumers in the electronic care planning system did not demonstrate that staff write or speak about consumers in a respectful way. This especially relates to consumers living with dementia or other cognitive impairments and who have changed behaviours. A documentation review of sampled consumers showed that staff practices especially in relation to continence care were not always conducted in a dignified and respectful manner.

The Assessment Team found there was mixed information received regarding consumers being supported to exercise choice and independence. Consumers interviewed generally stated that they can make choices however observations, staff interviews and documentation review did not always demonstrate that, consumers were supported to exercise choice and independence especially for consumers living with cognitive impairments.

The Assessment Team spoke to staff to understand how they were supported to make choices in relation to lifestyle program and responded that consumers can participate or not participate in activities. There was no further information provided of alternative activities that may be considered should a consumer say no. There was no process in place that staff were aware of to determine when and how consumers can make decisions about involving family, friends, carers and others in their care. Staff interviews provided mixed responses with some staff indicating that it is important to let the next of kin know everything.

The Assessment Team received feedback from staff and management in relation to how they support consumers at the service to take risks. However, the process of assessing risk was not comprehensive and did not always contain sufficient information to support consumers to take risks in the safest possible manner to live the best life they can. The Assessment Team reviewed risk assessments for consumers and found it was not evident that consumers are competently able to undertake those risks or that there were risk mitigation or minimisation strategies.

The Assessment Team interviewed consumers who overall felt that their privacy is respected and staff knock on their door before entering. Management and staff provided examples of how they respect consumers’ privacy and keep personal information confidential with staff observed to be logging out of computer systems when they were not using the computers. However observations did not support that consumers privacy is consistently being respected. The Assessment Team observed staff entering a consumer’s room after knocking but without waiting for the consumer to respond. The staff member later advised the Assessment Team that the consumer has hearing difficulties and does not always hear the sound of the door knocking.

The Assessment Team observed staff administering eye drops to a consumer in the lounge room. Medication was also dispensed and given to consumers in the dining room. The Assessment Team asked the staff member questions in relation to privacy. It was observed that the rest of the medication round was completed in the privacy of consumer rooms. The Registered Nurse was observed to complete the medication round on the subsequent days of the Site Audit in the privacy of the consumer rooms. Additionally, foot care was provided to a consumer in the lounge room next to the activity table where there were 4 other consumers participating in an activity. There was no attempt to provide privacy for the consumer who was being attended to. This was ceased following this being raised with the rest of the consumer visits in the privacy of their own rooms.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement where the service committed to providing Toolbox education on interacting with clients, and the provision of education on Code of Conduct and rights of older people, collaboration and communication, dementia education, continence education, dignity and respect, manual handling and palliative care approach in aged care. The service also committed to undertaking a full review and assessment of care plans for the identified consumers and undertake a lifestyle survey with consumers and representatives to identify preferences for consumers. An occupational therapist is to be engaged to support the review of the leisure and lifestyle interests and activities and a new lifestyle coordinator has commenced at the service. A partner in care program was commenced to support care and lifestyle programs.

Whilst I acknowledge all of the actions that the approved provider will be implementing, I understand it will take some time to reflect demonstrated change and sustained compliance in these areas with some completion dates reflected at end of August 2023.

I find that the approved provider is Non-compliant with requirements 1(3)(a), 1(3)(c), 1(3)(d) and 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 Quality Standard has been assessed as Non-compliant as five of the five specific requirements have been found to be Non-compliant.

The following requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) were found to be Non-compliant.

The Assessment Team found that the organisation has policy, procedure and checklists which direct what consumer assessments should be completed and when. Management advised that consumers are assessed initially upon moving into the service and then are reassessed annually and when their needs change or an incident occurs. The policies and procedures include some guidance about what is to be included in consumer care plans, but not always sufficient guidance. Management advised that after the initial care plan is completed (populated from completed assessments), the care plan is reviewed annually and is otherwise updated as assessments are updated.

Information gathered by the Assessment Team across Standard 2 shows that the policies, procedures and checklists have not been followed. Consumers’ assessments and care plans are not comprehensive or up to date, lack detail to inform care and service delivery, and some include conflicting information. Also, some assessments are not completed when due or in a timely manner when needed; or are completed by personnel who are not involved in the day-to-day care of the consumer or are not appropriately qualified to undertake the assessment.

The Assessment Team identified that pain assessments were not current and had not been completed for all consumers. The Assessment Team identified that some care staff write about ‘assessing’ the consumers sampled in progress notes after there has been a change in the consumer’s condition or an incident has occurred, noting they are not appropriately qualified or skilled to undertake clinical assessment. The admission guide states that mobility assessments are to be completed on day one and are to be completed by a Registered Nurse, this was not evident for all consumers.

A review of the care and service records for the consumers sampled showed that assessment and planning does not reflect their current needs, goals and preferences. Management advised that they are in the process of introducing case conferences and have contacted consumers and their representatives however none had been completed during the time of the Site Audit. In relation to advance care planning and end of life planning it was found that some consumers had an advance care directive and palliative and end of life care plans, but they did not contain any detail to guide staff in delivering the care.

The Assessment Team reviewed behaviour support plans for consumers and identified that they do not include the information required under the Quality-of-Care Principles and do not reflect best practice in behaviour support. They do not have information about the consumers to understand their behaviours and have mostly generic behaviour support interventions and do not include tailored activity interventions. A review of end-of-life care plans did not include any information about end of life goals and needs and how staff are to meet them. One end of life care plan did not record up to date information about medication and had conflicting information about hydration. Other assessments and care planning did not have information which identified or addressed the consumer’s needs and preferences relating to pain management, swallowing difficulty, falls prevention, bowel management or wound care.

The service did not demonstrate partnering in care with consumers in relation to assessment and planning. It was not evident in the care and service records of any of the consumers sampled that planning occurred in partnership in relation to Standards 1, 3 and 4. While staff did keep in contact with consumers and their representatives it was not evident that they were actively involved and given opportunities to contribute to the assessment and planning. Referrals were made and other organisations, individuals and providers of care were involved in the care of consumers, however it was not evident that they were always involved in the assessment and planning process. There were no discussions recorded with the consumers about their goals and preferences with goals listed been generic in nature and not individualised to the consumer.

The Assessment Team spoke with management and staff to understand how outcomes of assessment and planning are communicated to consumers and their chosen representative. A key point to note was that a lack of assessment was occurring which resulted in a lack of care planning meaning that there were minimal outcomes to communicate. It was found that care staff played a key role in the communication as opposed to registered staff.

The Assessment Team reviewed consumers documentation and found that care staff were in contact with representatives when qualified staff were not available. This resulted in representatives not necessarily having accurate clinical information due to the care staff not being appropriately qualified but were relied on to undertake the communication. Other information completed by care staff following consultation with representatives does not indicate what was discussed. Outcomes of assessment post incidents were not always communicated with representatives or there were instances where there was no assessment.

The service was not able to demonstrate that care and services were reviewed regularly for effectiveness, when circumstances changed or when incidents impacted on the needs, goals and preferences of the consumers sampled. There is a lack of initial assessment and planning conducted and as a result, care plans are incomplete and ineffective even before a consumer’s circumstances change or incidents occur.

The Assessment Team identified that recommendations from Dementia Services Australia had not been followed. It was also identified that post fall clinical monitoring and review of care for falls prevention was not undertaken.

The Assessment Team notes numerous medication incidents, including some with significant risk to consumer health and well-being have not been identified and reported in a timely manner or at all. The Assessment Team also notes other incidents, such as behavioural incidents and skin injuries, which have not been reported as incidents and that there was a lack of monitoring for injury when a consumer was involved in an incident with another consumer. The Assessment Team notes that when an incident report is raised this prompts staff for details of investigation. These details are not evident for the consumers sampled (noting no incident report and this is not otherwise evident in their care and service records). It was not demonstrated their care and services are being reviewed for effectiveness in preventing incidents to inform safe and quality care and services into the future and for some consumers incidents have continued to occur.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement including evidence of care conference invitations, behaviour support plan policy, education completed and a number of actions including completing full assessment and care plan of all consumers in consultation with consumer/representative including risk assessments and lifestyle assessments. Employment of a 24/7 Registered Nurse for clinical oversight and to mentor Registered Nurse and Clinical Nurse Manager on Roshana policies and procedure on all incident management and organisation processes on completing assessment care plan especially in response to a change or deterioration in condition. To provide job description and duty statement related to roles to all staff and incorporate this process at induction for new staff. Send memo to staff outlining organisational policies regarding qualified staff assessing deterioration and escalation process and Registered Nurse supervise care staff and ensure they escalate to Registered Nurse any changes in condition. Provide Toolbox talks and education to staff on falls, high impact/high prevalence risk – managing nutrition and hydration, mobility & dexterity, skin care & wound management, end of life care, participation in the implementation of individualised plan, management of unexpected deterioration, SIRS and dementia. The provider also provided a copy of the invitation for care conference and satisfaction survey which was sent consumer’s representatives on 24 May 2023.

Whilst I acknowledge the immediate actions that the provider has undertaken, I understand that it will take some time to reflect that these actions will demonstrate sustained compliance.

I find that the approved provider is Non-compliant with requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 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. | Non-compliant |

**Findings**

The Quality Standard has been assessed as Non-compliant as seven of the seven specific requirements have been found to be Non-compliant.

The following requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) were found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who were generally satisfied with the care of consumers. There is some policy and procedural guidance for staff regarding consumer personal and clinical care. However, documentation reviews, staff interviews and observations made, show the consumers sampled have not been getting safe and effective personal and clinical care. The care provided to them has not been consistent with best practice, it is not tailored to their needs and it has not optimised their health and well-being. The information gathered also shows poor medication management practices posing significant risk to the health and safety of consumers.

The Assessment Team identified that the organisational policies and procedures providing staff with guidance regarding pain management, post-fall clinical management, continence care and wound care do not consistently guide staff practice and, in relation to wound care, are not able to be implemented. This is because policy and procedure does not foresee a role for care staff in wound care yet management advised that care staff are involved in consumer wound care, for simple wounds, and Registered Nurses are to undertake assessment and treatment of complex wounds.

The Assessment Team were advised by management that if a consumer has an unwitnessed fall or fall with head strike and is taking anti-coagulant medication, the ambulance must be called so assessment of the consumer can be arranged and the consumer is not to be lifted or moved from the floor post-fall until they have been assessed by a Registered Nurse, which may mean that care staff have to get in touch with the on-call Registered Nurse for a remote, guided assessment (by voice, not visual so relying on care staff to provide an accurate description of the consumer). The Manager also advised that care staff can undertake consumer clinical observations, such as vital signs and neurological observations. In the main this has not occurred for the consumers sampled.

The Assessment Team identified that there has been a lack of behaviour support and there has not been assessments to understand the consumer’s behaviours with behaviour support plans not reflecting the information required by the Quality-of-Care Principles. In the main there are no tailored behaviour support interventions; where there are, they are not implemented by the care staff. Dementia Service Australia recommendations were not followed. There has been impact of the lack of and ineffective behaviour support on other consumers where consumers are intruding into consumers rooms and demonstrating aggression or inappropriate advances. There is also risk associated with a consumer who absconded.

Due to current staffing, there is a lack of qualified clinicians on site to administer medications to consumers at the service, although when the Registered Nurse in on duty, medication is administered by them. The manager advised, and organisational medication management policy and procedure reflects, that care staff deemed competent in medication administration can give consumers S8 medications under delegation by a Registered Nurse. They can also give consumers medication on an as needed (PRN) basis, but only with prior authorisation from a Registered Nurse. All of the information gathered shows that care staff considered medication competent are not following steps to enable safe and correct medication administration to consumers.

The Assessment Team interviewed consumers and representatives who were generally satisfied with the care of consumers. However, documentation reviews, staff interviews and observations made show high-impact and high-prevalence risks associated with the care of the consumers sampled have not been effectively managed.

There are organisational policies, procedures and checklists providing staff with guidance regarding managing risks such as falls, constipation, unplanned weight loss/nutrition deficit, and skin injuries. These have not informed staff practice in providing care to the consumers sampled. Deficiencies were identified for consumers with significant gaps in relation to falls risk, post falls monitoring and management and risk of complications from constipation, gaps in relation to unplanned weight loss/nutritional deficits and significant gaps in relation to skin injuries. Interventions, incident management and investigation.

The Assessment Team identified that there is organisational policy and procedure; these and end of life care resources are available to the staff, however, have not informed care provision. While the consumers sampled had an advance care directive, 2 consumers who recently passed away did not have an end-of-life care plan. Documentation reviews and staff interviews did not show that safe and quality end of life care was provided to a consumer.

The Assessment Team interviewed consumers and representatives who were generally satisfied with the care of consumers. However, documentation reviews, staff interviews and observations made show deterioration or change in the condition of the consumers sampled had not been recognised and responded to in a timely manner.

Consumers and representatives interviewed did not have any feedback about the communication amongst staff or with other health professionals about the consumer’s condition, needs and preferences. Observation shows clinical/care staff handover occurs. However, documentation reviews and staff interviews show that information is not well communicated with relevant stakeholders about the condition, needs and preferences of the consumers sampled.

The Assessment Team attended a verbal clinical/care staff handover. There is a written handover tool and there are staff communication diaries where, for example, consumer medical appointments are recorded. There are also communication books, such as with the doctor and physiotherapist about individual consumers and the need for review of their condition and care or medication needs. The manager advised when the doctor visits the Registered Nurse or a care staff member is with the doctor for handover. However, documentation review and staff interviews show that these processes are not effective in ensuring effective communication about consumers and their needs. The doctor’s communication book includes entries about the consumers sampled. However, this is not commensurate with what appears in their care and service records about change or deterioration in the condition of the consumer or incidents which occurred, including with injury. The Assessment Team identified that the progress notes did not reflect the same information that was recorded in the doctor’s communication book or the physiotherapy communication book, where it only showed there were 4 falls recorded for physiotherapy assessment, however, did not include all of the consumers’ falls.

When a consumer returns to the service from hospital or a medical appointment effective handover is not always evident. This is particularly the case when care staff receive the consumer. There is limited information about treatment or post-treatment care needs for consumers. When asked how they know about the care needs of a consumer, care staff said they refer to the consumer’s care plan. However, review of care plans for the consumers sampled showed they do not reflect their current condition or their care needs, goals, preferences or risks associated with their care and how to manage them.

Consumers and representatives interviewed did not have any feedback about consumer referrals, but confirmed consumers have access to a doctor and to other health and allied health professionals. In the main documentation reviewed and staff interviews do not show that consideration has been given to referring consumers to their doctor or other health and allied health professionals for assessment and advice to inform safe and quality care delivery.

The doctor’s communication book and consumer care and service records show some of the consumers have been referred to their doctor when there has been a change or deterioration in their condition or an incident has occurred. The physiotherapy communication book and consumer care and service records show some of the consumers sampled had been referred to the physiotherapist post-fall. Consumer care and service records also show some of the consumers sampled had been referred to and were being seen by a podiatrist; and the podiatrist was at the service seeing consumers one day during the Site Audit. Dementia Support Australia were consulted about the changed behaviours of a consumer and a referral was made about another consumer.

However, referrals are not made to the consumer’s doctor each time there is a change or deterioration in their condition or an incident occurs impacting on their condition and care needs. Referrals are not made to the physiotherapist each time a consumer has a fall. While Dementia Services Australia were consulted about a consumer’s changed behaviours and behaviour support needs, the recommendations made were not implemented.

Some consumers have been referred to their doctor or other health or allied health professionals. However, other consumers have not. There are numerous examples of this for the consumers sampled. Input from the doctor and other health and allied health professionals is not evident in many cases or recommendations made are not followed. This is impacting on safe and quality care delivery for consumers.

The Assessment Team identified there is an outbreak management plan to guide management and staff practice. The Facility Manager is the Infection Prevention and Control (IPC) lead for the service. Based on observations made, interviews with staff, consumers and representatives, and documents reviewed some precautions are being implemented for IPC. One representative reported that staff are always washing or sanitising their hands and they wear masks and wore other personal protective equipment during COVID-19 outbreaks.

However, the Assessment Team observed during the Site Audit that on entering the service there was no signage advising people to not proceed if they had any symptoms of an acute respiratory illness such as COVID-19. Other than rapid antigen testing and asking whether they had been vaccinated for influenza and COVID-19, there was no pre-entry health screening for visitors evident at the entryway/sign-in area. The Assessment Team was not asked to systematically answer, for example, whether they had been exposed to COVID-19 in recent days. At the entryway/sign-in area there were no wipes to sanitise shared equipment between uses, like the pens noting there were clean and used receptacles for the pens and only 2 pens. There was no signage about cough/sneeze etiquette within the service.

The manager advised the next morning that pre-entry health screening information and cough/sneeze etiquette posters were there but had fallen down and were not readily visible. She advised they or different posters had been put in place and wipes had also been placed at the entryway/sign-in area.

The Assessment Team reviewed minutes from a staff meeting on 20 March 2023 show staff mask wearing was discussed and the Clinical Nurse Manager asked 'So why do staff continuously not have them on? Staff stated they do wear them most of the time, but the Facility Manager stated that when she comes over to hostel a lot of the staff are not wearing them’.

The Assessment Team observed that staff are not wearing masks at all or correctly. Staff were observed to have masks around their chins, exposing their nose and mouth, face masks under their nose or no face masks at all. The Facility Manager/IPC lead said reminders have been given to staff about mask wearing and her observations are their IPC practices are good, it is just the mask wearing and added that this would be followed up.

The Assessment Team found that practices to promote appropriate prescribing and use of antibiotics for the consumers sampled were not evident. There have been delays in identifying consumer infection and arranging treatment, including with antibiotics.

Review of staff meeting minutes shows antimicrobial stewardship (AMS) was added to the agenda in March 2023. At the meeting on 17 May 2023 there was discussion about trying to decrease antibiotic use by educating doctors to order pathology and review results before prescribing and staff were also to encourage consumers to drink fluids. Minutes of the MAC meeting from January 2023 do not show any discussion about AMS. Minutes of any more recent MAC meetings or other ways of promoting appropriate prescribing and use of antibiotics to doctors were not provided.

Overall, it was not demonstrated that infection-related risks are being minimised through standard and transmission-based precautions with ongoing poor mask wearing practice by staff. Practices to promote appropriate antibiotic prescribing and use were not evident for 2 consumers sampled, with delays in identification and treatment for infection.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement and documentation to evidence actions already completed. The Plan for Continuous Improvement included Toolbox and education for staff on medication management and healthcare worker roles and responsibilities, palliative care: approach in residential aged care, recognising deterioration and escalation to RN, falls management and continence management. The provider has committed to reviewing progress notes to ensure that referrals are occurring.

I acknowledge the actions that the provider has immediately implemented, however understand that it will take some time for these actions to reflect sustained compliance with most actions to be in place by end of August 2023.

I find that the approved provider is Non-compliant with requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g).

**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. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Non-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. | Non-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. | Non-compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

**Findings**

The Quality Standard has been assessed as Non-compliant as five of the seven specific requirements have been found to be Non-compliant.

The following requirements 4(3)(f) and 4(3)(g) were found to be Compliant.

The Assessment Team interviewed consumers and representatives who overall provided positive feedback about the food and meal service. The service provides opportunities for consumers to give feedback about the food, and the feedback is used to adjust the meals to reflect the consumers’ needs and preferences. Most consumers interviewed expressed satisfaction with the variety, quality and quantity of food being provided at the service. Comments from consumers included: ‘the food is pretty good’, ‘I enjoy the variety of meals that are on the menu’. The Assessment Team were advised that the service has a winter and summer menu which is reviewed by the Facility Manager and dietitian. The meals are made on the premises each day. Specific dietary needs and preferences of consumers are accommodated into the menu or individualised meals are prepared as requested. The service creates an opportunity for consumers to discuss food at the residents’ meetings and the cook will sit down with consumers and ask consumers questions about the meal after meals to gauge their satisfaction. The organisation’s hospitality manager visits the service regularly and checks in with the consumers about their meal satisfaction. The large dining room windows are north facing providing a pleasant outlook overlooking the service’s gardens and the town’s cricket ground. The dining environment supports social engagement and a sense of belonging and enjoyment.

Consumers confirmed they feel safe when using the service’s equipment and said it was suitable for their needs. Consumers said they were comfortable raising issues if equipment needed repair. Laundry and catering staff knew the process for reporting an issue and said most items were replaced when necessary. Equipment used for activities of daily living were observed to be safe, suitable, clean and well-maintained.

The laundry/cleaning staff ensures there is enough supply of linen to last 3 days to cover the needs of the service over the weekend. Care staff interviewed confirmed they have no concerns with linen shortages. In relation to cleaning, the laundry/cleaning staff said they have access to equipment and chemical supplies to meet their needs adequately. Maintenance said they have no concerns with accessing the resources and equipment they need. The maintenance logbook indicated reactive maintenance is attended to promptly and all staff knew the process for logging a maintenance issue.

Staff interviewed said they have access to the equipment and resources they need to facilitate the activities at the service. The Assessment Team’s observation of lifestyle resources confirmed this. The Assessment Team’s observations of the kitchen confirmed staff have areas to complete services safely. The kitchen and food storage area were old but clean and tidy. However, the main kitchen did not have an operating dishwasher. The absence of a dishwasher in the kitchen has been considered under Standard 5 Requirement (3)(c).

I find that the provider is Compliant with requirements 4(3)(f) and 4(3)(g).

The following requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d) and 4(3)(e) were found to be Non-compliant.

The Assessment Team identified that consumers have not been getting services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life. Staff interviews, documentation review and observations did not support consumers have been getting the services and supports that they need or want.

Consumers sampled did not have assessments and care plans completed to guide staff in providing services and supports for daily living. A review of Key 2 Me assessments showed that at least 12 of 20 consumers did not have an assessment completed which meant they also had incomplete therapy, leisure and lifestyle care plans. The Facility Manager advised that these assessments and care plans are an essential part of providing consumers with the supports that they need and want.

The Assessment Team observed 2 consumers, sitting on the lounge for a majority of the day looking at the television or appearing to be sleeping, there were no other engagement noted by the Assessment Team during their observations.

Staff interviewed stated that consumers can sometimes get lonely. They expressed challenges faced in relation to being short staffed and it being difficult since the full-time recreational activity officer left the service. Care staff do what they can such as sit with consumers, watch movies and have a chat with them. They try to do the best they can. It was observed on the final day of the Site Audit that care staff were assisting consumers to play bingo. Overall it had not been demonstrated that consumers have not been getting services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life.

The Assessment Team found that there has been a lack of assessment and care planning to understand consumers’ needs and preferences regarding emotional, spiritual and psychological support and to guide staff in delivering services and support. Observations made by the Assessment Team, staff interviews and documentation reviewed shows that some consumers have not been supported with their emotional, spiritual and psychological well-being. The lack of Key 2 Me assessments mean information has not been captured about the emotional, spiritual and psychological needs and preferences of the consumers. It also means their therapy, leisure and lifestyle care plans lack information about their needs, preferences and interventions to support them.

The Assessment Team interviewed consumers and representatives and had mixed feedback. One consumer stated that they feel they can talk to someone if required. Another consumer stated they felt emotional with the transition to the service from the retirement village however feels supported. However, one consumer raised concerns about the admission to the service and said that the whole process was very upsetting and has felt emotionally distressed. Management explained that the service has access to the older persons mental health service in a nearby town, can refer consumers to doctors and access mental health support services through the public health network. However management stated that no consumers are currently engaged with these services.

There is no information in the incident report or progress notes about monitoring the consumer’s emotional state or providing the consumer with emotional support following an incident with another consumer. The consumer’s representative was not familiar with the incident, so was unable to comment on whether he was supported emotionally.

The Assessment Team spoke with multiple staff members, all provided different responses regarding the frequency of visits and which days religious clergy visit. The Assessment Team were advised that if a consumer needed pastoral care support in a situation like for end of their life care, they would look on the internet for local community pastoral care providers. The Assessment Team observed a service took place during the Site Audit.

Although the service has links to mental health services, staff do their best to provide emotional support and there are some church services, the information gathered does not show that the emotional, spiritual and psychological wellbeing of each consumer is being supported. There is ambiguity around processes to support consumers when the need for support is identified, there has been a lack of related assessment and care planning, and documentation does not show

The Assessment Team reviewed the activity calendar from May 2023 showed reoccurring activities – reading, music, movies, television, exercises, bingo, crossword, trivia, nail salon, darts and word games. Due to the lack of assessments it was not demonstrated how these are known to be things of interest to the consumers. It was not clear how consumers would be supported when they would like to do activities not on the calendar, including one to one. There was no activity calendar for June 2023 created due to the previous activity officer having ceased working at the service. The Assessment Team were advised that consumers have choices to attend or not attend the group activities. No mention was made of how consumers would be supported to do things of interest to them should they not wish to.

Consumers and representatives interviewed did not have any feedback about the communication amongst staff or with other health professionals about the consumer’s condition, needs and preferences. The Assessment Team found that information regarding consumers’ condition, needs and preferences is not being accurately captured and communicated within the organisation and with others where care is shared. Staff interviews demonstrated that there is not a clear understanding by management and staff of the supports and services available to consumers, including for effective coordination. The information staff are relying on, such as care plans, are not always accurate and up to date.

The Assessment Team observed for one consumer who is supported by NDIS to attend community activities information staff are relying on is not accurate or current. The staff communication book states the service has changed days from Fridays to Thursdays. However, the staff advised the Assessment Team that the service provider picks the consumer up every second Friday. The Assessment Team observed the Registered Nurse talking to the consumer, asking the consumer if the consumer’s ‘friends’ were taking the consumer out that day. It was Wednesday. The consumer then went and got ready to go out. The consumer sat in the chair for several hours and was later told by the Registered Nurse ‘I don’t think they are coming today’. The consumer did not go out.

Staff at the service all provided different answers in relation to the religious services. One staff member said that church services occur on Sundays and mentioned that the services use to occur on Wednesdays, however as the local priest moved away services do not occur on Wednesdays and even some Sundays either. One staff member said that church services occur once a week on Thursdays, another staff member said that church services occur on Wednesdays and Sundays however was not able to state what denomination the visiting clergy were from. The manager stated that church services occur twice a week.

The Assessment Team were advised that staff write in the communication book, noting there were 2 books observed at the nurses’ station which both contained the same types of information which posed a risk as key information or communication may be missed or written in the wrong book. Staff advised that they share information through handovers and verbal communication.

Consumers interviewed gave information about being seen by other providers of services. Staff provided examples of referrals they have made and management gave examples of other providers that the service works with including physiotherapist, hairdresser and podiatrist.

However, the Assessment Team found that there was confusion about the church and pastoral care services, including how they can be accessed, when they regularly occur and which religious denominations the clergy belong to. Management gave examples of psychological and mental health services that they have access to, however were not able to provide examples of consumers who have or are accessing these services.

It was noted that consumers have been referred to Dementia Service Australia however it was not always evident that this occurred in a timely manner and recommendations were not considered in consumers’ care plans, including behaviour support plans and as related to meaningful occupation for them. The Assessment Team notes that the service has avenues to make referrals and there is evidence that some referrals are occurring however there was confusion about their availability and how to access them.

The approved provider responded to the Assessment Team’s report with actions completed and the Plan for Continuous Improvement. The provider committed to meeting with consumers and representatives to complete key to me assessment for all consumers in consultation with consumers and representatives and update leisure and lifestyle assessment & care plan with his needs, goals and preferences and emotional and spiritual needs. A new lifestyle co-ordinator has commenced at service, and a lifestyle activities survey is to be completed to identify consumer’s needs, goals and preference to assist in creating the activity calendar. An occupational therapist will be engaged to support lifestyle co-ordinator in reviewing activity calendar and updating assessments and behaviour support plans. The activities calendar will be displayed in consumers rooms and notice board to provide information to consumers and staff. A directory will also be provided to staff on local support services available for easy access.

I acknowledge the actions taken and the planned actions the provider is taking to address the Non-compliance, however I understand that this will take some time to reflect sustained compliance.

I find that the approved provider is Non-compliant with requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d) and 4(3)(e).

**Standard 5**

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

**Findings**

The Quality Standard has been assessed as Compliant as three of the three specific requirements have been found to be Compliant.

The Assessment Team observed the service environment to be well presented with indoor and outdoor areas for consumers and visitors to enjoy. The bedrooms are off the one corridor with the key places, such as the lounge room, dining room, and servery area in the centre of the building. The building has good visual access for people with a cognitive impairment as well as for the staff to see the consumers.

The environment décor is welcoming, comfortable and functional. The bedrooms are furnished with personal items and the personal backgrounds of the consumers are reflected in the environment.

Consumers and representatives said they feel at home in the service environment and think it is a nice place to live. Representatives said they feel welcomed by staff members and there are sufficient indoor and outdoor areas to spend time with their loved ones.

The Assessment Team found that overall the service demonstrated that there are processes in place for a well maintained, safe and comfortable environment. The Assessment Team observed the environment appears safe, well-maintained and comfortable for consumers and is clean. Consumers are able to move freely, both indoors and outdoors and consumer and representative feedback was positive about the environment. Consumers and representatives provided feedback that cleaners come in every day to clean the room with one representative saying that on visiting, they have always found the service clean and tidy. Other consumers and representatives interviewed indicated they consider the service environment to be generally clean, safe, well-maintained and comfortable.

The maintenance officer does not have a formal schedule of preventative maintenance but when the Assessment Team asked for specific evidence of preventative maintenance, the maintenance officer was able to demonstrate when it was last attended to.

The following requirement 5(3)(c) was found to be Not Met by the Assessment Team as the service was not able to demonstrate they purchase, service and maintain fittings and equipment that are safe and suitable for the consumer. The Assessment Team observed wall-mounted hydronic heaters in use in the hallways of the service directly under the handrails used by consumers. The heaters were extremely hot to touch. The heaters did not have guards around them to prevent consumers from coming into direct contact with the hot surface. On 24 May 2022 all aged care residential services received a clinical alert from the Commission’s chief clinical advisor that hydronic heaters are a risk and it is important that they identify and reduce the associated risks to consumers. The management was asked if they had a copy of a risk assessment they have completed where they have identified, and mitigated risks associated with use of the hydronic heaters. The manager said they do not have any risk assessments.

The service has a main kitchen and a servery area. The meals are prepared and cooked in the main kitchen and transported to the servery to reheat and serve. The servery had an industrial dishwasher which stopped working. The service was unable to get a technician who would travel to the small town to service the dishwasher. The service decided to install a new domestic dishwasher in order to have some form of cleaning and sanitising of food equipment at the service. The Assessment Team were advised that while the consumer crockery and eating utensils are washed in the dishwasher in the servery all cooking equipment is washed by hand in the main kitchen as it does not fit in the dishwasher.

The kitchen staff have completed a safe food handling course and is aware that while hand cleaning removes all visible dirt, chemical residues and allergens from equipment it is difficult to sanitise if the right water temperature is not obtained. Sanitising reduces the number of microorganisms to a safe level. Hand cleaning only without sanitising increases the chances of cross-contamination.

The organisation is planning to completely refurbish the main kitchen. During this period they will shut the kitchen at the service down and complete all cooking at the nearby service which is 15 minutes away. They are in the process of getting building quotes for the service’s kitchen.

The dining room curtains have rips in them. The consumers discussed this at the resident meeting in April and in May 2023. It was decided by the service they would get quotes and replace the curtains. A consumer organised for a person to come to the service and provide a quote for the curtains. This quote was provided to the procurement team but was not approved at the last meeting. The service identified the curtains being worn and itemised them in their continuous improvement plan on 23 September 2022. The ripped curtains still remain in the dining room.

A care staff member said they have complained at staff meetings for some time about the lack of a generator. When the power goes out, as it does at times, staff can’t do anything, they don’t even have lights and have to wander around with torches. Another staff member said the service has electric hot water which is affected when the electricity goes out.

Staff meeting minutes from March 2023 include: ‘staff asked if a generator is being looked into’. The ‘FM stated "why do we need a generator" staff stated the electricity can be out for hours and there is no electricity, no lights, no hot water, no phones and no computer systems.

The Facility Manager said the service has had their electricity go out once since she started working at the service in August 2022. The electricity was put back on within the hour. The Facility Manger said hospitals and residential aged care services are considered high priorities by the electrical company and they will prioritise the service to have their electricity put back on first. The general manager provided a quote from a local service where they can connect a portable generator to the service’s system, when the electricity goes out at the service. At the time of the Site Audit the service has not gone ahead with the generator.

The Assessment Team reviewed minutes of a staff meeting held on 18 January 2023 with staff advising that some consumers need sensor mats and had been told these were ordered, but the staff had not yet seen them. It is recorded the staff said they have only 2 and one was purchased by a consumer’s relatives as they were concerned for her welfare.

The Assessment Team requested details of the equipment held, including bed sensors. The asset register showed there was one bed sensor, 4 pressure mats, one crash mat. The Assessment Team observed there were more bed sensors at the service than this. The Assessment Team observed there were 2 bed sensors in the room that the team was located as well as crash mats, appearing in good condition or new/in packaging; and in the Facility manager’s office there were more bed and chair sensors which the Assessment Team observed. This does not demonstrate that the service understands what equipment is held and available for deployment when the need is identified.

The approved provider responded to the Assessment Team’s report and provided documentation of actions already taken and the Plan for Continuous Improvement. The provider advised that the preventative maintenance schedule is now in place and the hydronic heaters are to be removed from the service, an industrial dishwasher was installed in the main kitchen on 20 June 2023. The provider has approved the quote for new curtains and for the purchase of a portable power station to use for equipment during blackout, a generator will be provided for extended blackouts. A new facility management interface software has been implemented to record and manage equipment available at the facility on 16 June 2023.

I have considered the actions completed and the immediate planned actions that are to be completed by end of July 2023 and feel that these actions have addressed the Non-compliance raised by the Assessment Team.

I find that the approved provider is Compliant with this requirement.

**Standard 6**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as one of the four specific requirements have been found to be Non-compliant.

The following requirements 6(3)(a), 6(3)(b) and 6(3)(c) were found to be Compliant.

The Assessment Team interviewed consumers and representatives who said they understand how to give feedback and would feel comfortable if they were to provide feedback or make a complaint. Most consumers said if they need to provide feedback, they will just talk to the staff or the Facility Manager informally and it will be dealt with or fixed for them. Representatives said that they would not have any hesitation complaining if the need arose. Consumers said that they have no real complaints.

Staff were able to describe how consumers feel comfortable with staff members because they have built relationships with consumers and representatives and usually resolve complaints ‘on the spot’ whenever possible or escalate complaints to a Registered Nurse.

Resident meeting minutes show the consumer voice in the minutes. Consumers raise concerns in the meetings on a regular basis and there is evidence in the minutes that show these concerns are sometimes followed up by the service.

Consumers and representatives confirmed that they are aware of how to access advocacy services and feel comfortable in doing so with advocacy services being promoted at the service. Consumers have access to other methods for raising and resolving complaints.

The Assessment Team were advised that no consumers at the service require translator or language services as they all speak English however that they would seek these services when and if required The Assessment Team observed advocacy service brochures and brochures about the external aged care complaints mechanism in the service at the main entry point of the service.

The Assessment Team received feedback that confirmed that consumers and representatives are satisfied that the service will address and resolve any complaints or issues they raise. Staff described how they try and help consumers to resolve their concerns and management demonstrated principles of open disclosure are followed with formal complaints.

The service does not have a complaints and feedback register as they have had only one formal complaint this year. The complaint was in relation a consumer’s appearance which was reported to be dishevelled and unkept. The Facility Manager apologised to the representative and advised the representative that it would be investigated. The Facility Manager undertook an investigation and contacted the representative who indicated they were satisfied with the outcome. This was also confirmed to the Assessment Team when the representative was interviewed. The representative was provided an honest answer and was reassured the staff will try to minimise this from occurring again.

While the Facility Manager demonstrated an open disclosure process is used when complaints are made, the care staff interviewed did not understand the term open disclosure even when prompted with an example by the Assessment Team. However based on the one complaint this was found to be Compliant.

The following requirement 6(3)(d) was found to be Non-compliant.

The Assessment Team received feedback from consumers and representatives who said they are satisfied their feedback is used to improve the quality of care and services. Documentation shows that many issues are canvassed at the resident meetings which are currently held monthly. Minutes indicate that this meeting seeks to gain consumer opinion on a broad range of issues including those related to care, lifestyle, catering, cleaning and laundry services.

Resident meeting minutes indicate that some complaints canvassed at the meetings are followed up with by management and progress reports or outcomes are provided to the consumers at the following resident meeting. However, the complaints raised at these meetings do not populate over to the service’s complaints system.

Interviews with consumers, representatives, staff and the Facility Manager suggests that most complaints are managed informally. This informal process makes it difficult for the service to analyse and identify complaint trends and feed into the service’s continuous improvement plan.

The service’s continuous improvement plan was last updated in October 2022. The Assessment Team reviewed the continuous improvement plan and noted none of the entries have feedback/complaint as the source of the improvement initiative and none reflect improvements are being made in response to consumer feedback and complaints.

Management advised the Assessment Team they currently do not have a complaints and feedback register as they have had only one complaint this year. However, the complaint did outline the complainant, complaint/feedback, outcome and evaluation of the complaint.

When management was asked about some changes that have been made at the service as a result of feedback or complaints made by consumers, the team were provide with 2 examples including the ripped dining room curtains. The consumers discussed this at the resident meetings in April and in May 2023. However, the Assessment Team notes, the service had previously identified the curtains being worn and in need of replacing in their continuous improvement plan on 23 September 2022. The ripped curtains still remain in the dining room.

The Facility Manager said the consumers raised concerns in the resident meetings that they do not have a full-time cook at the service. The Facility Manager said the service responded by obtaining a full-time cook. However the resident meeting minutes do not indicate a complaint was raised by the consumers. The Commission received an anonymous complaint on 14 March 2023 relating to concerns about the ‘care staff cooking the evening meal 5 out of 7 nights a week. The complaint stated the care staff have no food training and do not have a food safety certificate. The care staff go between toileting consumers and cooking the meal on a regular basis. Their concern is that a consumer may become seriously ill from this situation’.

While the service now has a full-time cook during the weekdays and a cook from the nearby residential aged care service cooks at the service on the other days, the evidence reviewed by the Assessment Team does not indicate this complaint came from a consumer.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement which included Toolbox education on Incident Reporting including open disclosure and that the service will reinforce logging of feedback into the organisation’s electronic feedback management system for analysis and trending.

I have considered the approved provider’s response, and the lack of formalised feedback and complaints to improve the quality of care and services. I understand that it will take some time to reflect sustained compliance with this requirement to ensure that feedback and complaints consistently influences improvements at the service.

I find that the approved provider is Non-compliant with requirement 6(3)(d).

**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. | 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 Quality Standard has been assessed as Non-compliant as three of the five specific requirements have been found to be Non-compliant.

The following requirements 7(3)(b) and 7(3)(e) were found to be Compliant.

The Assessment Team interviewed consumers and representatives who all said staff are kind and caring in their interactions with them on a day-to-day basis and are gentle when providing care to consumers. They believed staff understood the needs of consumers and did their best to ensure their needs were met.

Staff demonstrated an in depth understanding of consumers interviewed. However, this information was not reflected in the consumers’ care and service records and staff sometimes write or speak about consumers in a disrespectful way (this has been considered under Standard 1).

Most staff said they have completed a performance appraisal in the past year. Management advised they monitor and review staff performance through observations and annual performance appraisals. Most care staff said they think they have completed a performance appraisal, however 2 care staff said they have not completed a performance appraisal in the past year. Management advised the Assessment Team that they informally review staff performance by observing staff practice and that they have been working hard to attend to all staff performance reviews and provided a spreadsheet with staff performance appraisal due dates, which indicated by the end of June 2023 they will have completed all staff appraisals.

Management said they are currently not performance managing any staff members.

The following requirements 7(3)(a), 7(3)(c) and 7(3)(d) were found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who said they are satisfied with the care they receive and believe the staff have time to deliver care and are not rushed. However, on review of the roster it was identified that there has been no clinical oversight by a Registered Nurse at the service since the Sunday morning before the Site Audit. Most rostered shifts for the fortnight before the Site Audit were filled, however 3 care shifts in the last fortnight were left unfilled and an agency Registered Nurse or Enrolled Nurse were used 5 times. The service does not use agency care staff. The service has a casual pool of 3-4 care staff which they can access when required.

Staff meeting minutes for March 2023 indicate care staff would like to start the morning shift at 6:30am rather than 7am as the roster dictates, due to most of the consumers already being awake by this time. The Facility Manager agreed with this request however the Registered Nurse commences at 7am. Handover is completed once when the Registered Nurse starts, it is unclear how effective communication about the consumers’ condition is communicated to the morning care staff before the Registered Nurse handover to ensure continuity of care occurs.

The mix of members of the workforce, as planned and as deployed, does not enable safe and quality care and services. Management advised that the current model of care at the service and in response to feedback from the Assessment Team about significant gaps in safe and quality care to consumers, said the situation is not ideal.

They advised they are seeking to increase Registered Nurse hours at the service and have engaged a recruitment agency to recruit qualified staff from overseas. The organisation has just renovated a building onsite to accommodate staff to further entice qualified staff to come and work at the service.

The Assessment Team received feedback from consumers and representatives who considered the staff know what they are doing and are competent in providing the social and medical care they need.

The Assessment Team asked the Facility Manager how they know the staff are competent in their role. The Facility Manager replied they observe the staff on the floor and they also seek feedback from staff and consumers.

However observations made, records reviewed and interviews with care staff, including staff who the Assessment Team was told were medication competent, show that care staff do not have the knowledge required to effectively perform their roles as expected of them in this organisation and at this service.

Care staff are expected to undertake duties usually allocated to appropriately qualified staff: Registered Nurses or other nursing staff. This includes, as advised by the Facility Manager: administering medication on a PRN basis after obtaining authorisation from an Registered Nurse; administering high-risk medications such as schedule 8 medications, insulin and anticoagulants; undertaking simple wound care, however this includes initial assessment when there is no Registered Nurse on duty; supporting remote assessment of a consumer post-fall under the guidance of an Registered Nurse; and monitoring the clinical condition of a consumer post-fall and escalating any clinical deterioration.

The Assessment Team interviewed staff and found that some care staff were aware of these duties and specifically the need to seek authorisation or guidance from the on-call Registered Nurse. However, others were not. For example, a care staff member said they get consumers up off the floor without any Registered Nurse (or other health professional) involvement; and another care staff member said they refer to the senior care staff member who assesses the consumer and decided whether to get them up. Another care staff member said they can give PRN medication to consumers without needing Registered Nurse authorisation.

The sampled consumer’s care and services records for consumers who had experienced falls, indicated they were gotten up off the floor without any RN (or other health professional) involvement.

Review of consumer wound care records show care staff are involved in wound care, which is beyond simple wound care. When interviewed the Facility Manager said she was confident the care staff would be able to identify a change or deterioration in the condition of a consumer, as they know the consumers well. Review of the care and service records of consumers shows care staff are not identifying or escalating change or deterioration in the condition of consumers. Staff lack knowledge about dementia, the care of people living with dementia and behaviour support. They demonstrated a lack of understanding of changed behaviours in their responses to, and descriptions of, consumers living with dementia. Care staff interviewed did not, for example, identify the link between pain/discomfort and changed behaviour; and they did not understand the role of meaningful engagement in behaviour support.

Management was unable to locate staff training core competency completion documentation.

The Assessment Team were provided feedback from consumers and representatives that they believe staff know what they are doing and do not require further training. Staff and management said the service has an education calendar and this education and training are offered both face to-face and through online learning modules.

Staff said they have received training in a number of training modules including SIRS, open disclosure, falls management and continence management face to face, through the online training platform and through toolbox talks.

Toolbox talks included dignity and respect, continence/bowel care, skin care, documentation, feedback, SIRS, diabetes, falls, dementia and communication, behaviour management, medication management and post fall observations.

A training calendar was also provided to the Assessment Team showing the training the staff have completed to date and the training scheduled for the rest of the year.

When the Assessment Team interviewed staff and asked what their role is in regard to open disclosure, they were not able to recall what open disclosure is.

Care staff are not supported to undertake the roles expected of them at this organisation and within this service through organisational policy and procedural guidance. Care staff are involved in consumer wound care and not just simple wound care. Care staff are involved in monitoring the clinical condition of a consumer post-fall and escalating any clinical deterioration. The organisation’s related wound policy and procedure does not envisage that care staff have any role in consumer wound care, rather that this is a responsibility of Registered Nurses and enrolled nurses. The organisation’s falls prevention and management policy and procedure regarding an unwitnessed fall/fall with head strike does not envisage care staff being involved in this, rather Registered Nurses are to take vital signs, neurological observations and check for pain.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement and actions that have been implemented since the Site Audit. These include a Clinical Care Escalation Procedure implemented on 21 June 2023, a training plan to capture all outstanding training, medication competent staff have completed first aid training, Toolbox education in medication management and Healthcare workers roles and responsibilities has also been completed with a memo sent to all staff on their roles and responsibilities. The provider plans to employ 24/7 Registered Nurses for clinical oversight.

Whilst I acknowledge the immediate actions that the provider has initiated, I understand that it will take some time for staff to demonstrate sustained compliance and demonstrated competence in their roles.

I find the approved provider is Non-compliant with requirements 7(3)(a), 7(3)(c) and 7(3)(d).

**Standard 8**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as four of the five specific requirements have been found to be Non-compliant.

The following requirement 8(3)(a) was found to be Compliant.

The Assessment Team interviewed consumers and representatives who thought they had an opportunity to have a say in what happens at the service. The organisation has policy and procedure to guide management and staff in relation to consumer engagement. Most of the processes to support consumer engagement are occurring and there are examples of consumer engagement at service level. The Operations Manager outlined how consumer engagement is occurring and will occur in the future at organisational level and provided examples of this.

The Assessment Team reviewed policy and procedure which includes that consumer engagement takes place through case conferencing, meetings and networking with consumers and their representatives. Also through review of consumer care plans in consultation with them or their representatives, and via the feedback mechanisms such as complaints, surveys and focus groups.

The Assessment Team identified there has been a lack of consumer case conferencing and it was not demonstrated that care plans are developed or reviewed in consultation with consumers or their representatives. However, resident meetings and surveys have been occurring and there is an informal complaint mechanism. A food survey was undertaken in 2023 and the feedback used to inform menu development. As this is predominantly about what occurs at service level, the Assessment Team asked about consumer engagement at organisational level. The Operations Manager said he and his team visit the service and spend time with consumers and talk with their representatives. Also, the chief executive officer (CEO)/director visits the organisation’s services interacting with consumers and attending resident meetings. The latter was not evident for any of the resident meetings at Uralba Retirement Village in 2023 to date. The Operations Manager said this would have last occurred in 2022.

The Operations Manager advised a representative from each of the organisation’s services has been invited to form an advisory committee. The Operations Manager provided examples of having engaged with consumers at another of the organisation’s residential aged care services as they had concerns in common and how this led to organisation-wide service improvement. Also, of engaging with the representative of a consumer who had concerns about the consumer’s care and services involving them in evaluation and development and delivery of future care and services.

The following requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) were found to be Non-compliant.

The Assessment Team found that the organisation’s governing body consists of two directors who are the owners of Roshana Care Group and one of those directors is also the CEO. There are no governing body meetings. The Assessment Team interviewed the Operations Manager in relation to organisational governance.

The Assessment Team requested the organisation’s strategic plan to begin to understand whether and how a culture of safe, inclusive and quality care is being promoted. The Assessment Team also requested a recent operational plan to begin to understand through both of those documents how the governing body is and has been accountable for the delivery of safe, inclusive and quality care and services. These were not provided.

There is an organisational diversity and inclusion plan and other policy and procedure which promotes and supports safe, inclusive and quality care and services. The Operations Manager provided examples of the director/CEO’s involvement such as setting terms of reference for meetings and supporting implementation of new systems and processes, such as, but not limited to, a new e-suite of policies and procedures and new care checklists. However, effective implementation of these at the service is not evident as noted under other requirements across this report.

The Operations Manager advised he and an external consultant report to the CEO and provide him with information. There is a partners in excellence committee with organisational representatives, which meets monthly. The Operations Manager said the minutes of those meetings and reports are given to the CEO/director. The minutes of those meetings include information about service performance against the Quality Standards. The organisational clinical indicators report provided for April 2023 has information about consumer falls, wounds, unplanned weight loss, and infections. However, it does not include information about other clinical indicators such as behavioural incidents and medication errors.

The Operations Manager said he meets often with the CEO/director and while there are no formal meetings or records kept of those meetings, there is documented email communication between them. The OM said the consultant also meets with the CEO/director and there are heads of department meetings each quarter chaired by the CEO. Minutes of the heads of department meetings were requested but not provided.

An effective governance framework for promoting a culture of safe, inclusive and quality care and services was not demonstrated. Accountability for the delivery of safe, inclusive and quality care and services by the governing body was not demonstrated, noting information was not provided to corroborate the CEO/director’s awareness and involvement in directing and controlling the organisation.

An Assessment Contact was conducted at the service on 5 October 2022 and following this a regulatory official from the Commission decided that requirement 8(3)(c) was Non-compliant, the service was undergoing transition as a new approved provider had taken ownership, and there was a lack of communication regarding this with key stakeholders. Policies and procedures were not guiding staff practice and it was not demonstrated how regulatory changes would be implemented. A functioning feedback and complaints system was not in place and complaint trends were not guiding service improvements. Governance frameworks were still being developed and service performance had not been monitored.

The service’s Plan For Continuous Improvement to address the Non-compliance for this requirement were that the organisation’s systems and processes require implementation to provide organisation wide governance. The planned actions were to provide information to staff about the organisation’s current policies and procedures, job descriptions, compliance system including reporting requirement to head office, and feedback escalation process, to educate the staff on use of the new software systems, to implement the organisation’s software systems, the new e-suite of policies and procedures noting that system has other modules, and for finance and to contextualise best practice policies and procedures and roll out to all staff.

The information gathered from an assessment of compliance with the requirement during this Site Audit demonstrates that a new e-suite of policies and procedures was purchased by the organisation and in the main is accessible to staff at the service. Many of the policies and procedures which the Assessment Team was given access to had not been tailored to the organisation (noting prompts for even the ‘Organisation Name’ are remaining in the documents) or to reflect local circumstances at the service. Some policies and procedures are not able to be implemented because the model of care and staffing mix at the service do not allow this.

The Assessment Team identified that staff said they generally could access the policies and procedures and find the guidance they needed. However, a clinical staff member said the system cannot be accessed on the computer at the desk and has to access it on the mobile phone. Some staff were aware of their role and responsibilities as reflected in the policies and procedure, but others were not. Some of the policies and procedures were not being followed by the staff. The Operations Manager advised some policies and procedures from the new e-suite have been implemented, but not others.

The Assessment Team were advised that there are problems with Wi-Fi/internet access at the service, the staff said this also affects their access to the electronic care planning system and electronic medication records system. One of them said at least now they have printed medication records, which they can refer to if the electronic system does not work. Consumer progress notes show there are times when staff cannot access the electronic care planning system and/or the electronic medication records system.

The Operations Manager said staff have not escalated most of these issues so they can be addressed noting the organisation has 24-hour information technology support, however, was aware of a problem with the electronic medication records system. This is reflected in a risk corrective action report about medication variances, dated 1 April 2023 which notes ‘Ongoing issues with med-mobile and medications not appearing on medication profile’. The results reflect these issues have been resolved (no date of resolution), which is not the case according to staff including for a consumer who moved into the service in June 2023, the staff member advised that the consumer’s medication has only appeared in the system that morning, when the consumer had moved into the service a week earlier.

Self-assessment and evaluation are an integral part of continuous quality improvement. The organisation’s self-assessment of performance against the Quality Standards lacks evidence of self-assessment for some requirements and for many others does not reflect actual service performance.

While there are proposed corrective actions and there is also a service Plan for Continuous Improvement, these do not show sufficient or timely improvements have been made for safe and quality care. There are continuing poor results and outcomes for consumers. There is some oversight of organisational and service level improvements via the partners in excellence committee meetings, but these are primarily about the number of improvements and not about broader oversight of improvement activity.

The Operations Manager described the annual budgeting processes and the financial support provided to implement the organisation’s governing frameworks and policies and procedures. Management advised in relation to staffing and increasing Registered Nurses coverage, there is a financial commitment to provide this (the challenge is recruiting Registered Nurses). The Facility Manager said she has had access to funds to purchase items and make commitments when there has been a need to support consumer care and service delivery.

Documentation provided and discussions with the Facility Manager and Operations Manager show there is an awareness of local workforce challenges and that actions have been taken and are being taken to address this. While there has been oversight and there is an awareness of the challenges and risks relating to the workforce, there has not been a commensurate increase in support provided to mitigate significant risk to consumer health, safety and well-being. Since that meeting occurred in April 2023, the Clinical Nurse Manager has resigned the previous week. A new Clinical Nurse Manager was not due to commence until 19 June 2023. This means a reduction in day-to-day clinical oversight.

The Operations Manager and his team of clinicians have visited and spent time at the service, however, other than assessments completed by them for some consumers it is not evident they have been involved in directing, delivering and overseeing the day-to-day care of the consumers. While the Facility Manager said she has spent more time at the service, she is responsible for 2 of the organisation’s services and has to split her time between them. No other Registered Nurse or clinical support of note at the service has been evident to mitigate risk to the consumers.

The Assessment Team found that regulatory compliance obligations are generally reflected in organisational policy and procedure. For example, policy and procedure has been updated regarding approved provider governing body and key personnel obligations and about the aged care worker code of conduct, which both took effect in December 2022. Some regulatory obligations are being implemented, such as the aged care worker code of conduct and checking the Commission’s banning orders prior to employing new staff. There has been monitoring of the rates of staff training completion and acknowledgement of the code of conduct through the organisational partners in excellence committee meetings. The Assessment Team also acknowledges that use of restrictive practice has been minimised at the service consistent with obligations in the Quality-of-Care Principles.

However, other regulatory obligations are not being met. These include that appropriately qualified staff are not undertaking consumer assessment and therefore care planning and care is not being carried out by qualified staff. Behaviour support plans did not have all information required and care staff are responsible for S8 medication management, including holding the keys to the drug cupboard, checking medication out of the cupboard, making entries in the S8 drug register and administering medications to consumers.

There is governing body oversight of consumer feedback and complaints. This is evident in the partners in excellence committee meeting minutes, provided to the CEO/director. They have a summary of feedback and complaint trends and actions are recommended to address adverse trends.

In summary, there has been effective financial governance and governance of feedback and complaints. There has not been effective governance of information management, continuous improvement, the workforce or regulatory compliance.

The Assessment Team requested the organisation’s documented risk management framework. A documented risk management framework was provided, however was limited to infection-related risk and was not about broader strategic risk for the organisation.

The organisation’s e-suite of policies and procedures included information about an enterprise- wide risk management program. This clearly set out responsibilities of the governing body in relation to strategic risk management. However, implementation of the program was not demonstrated.

The Assessment Team requested the organisation’s strategic risk register. Risk corrective action reports were provided relating to the organisation and the service. These were predominantly clinical-related risks and one was about workforce-related risks. It was not demonstrated that organisational risk related to regulatory compliance (such as risk of breach) had been identified, the risk tolerance level identified, risk controls put in place or the inherent and residual risk assessed.

There are organisational policies and procedures to guide staff practice in high impact and high prevalence risk management. They have not been implemented at the service or in many cases are not being followed. There has not been effective management of high impact high prevalence risks associated with the care of consumers at the service.

There are organisational policies and procedures about abuse and neglect of consumers and related reporting obligations, including in relation to SIRS. However, these have not been implemented effectively at the service.

There is some awareness at organisational level of deficits in relation to consumer incident reporting and management. However, corrective actions have not mitigated the risks sufficiently or in a timely manner. There is some awareness at organisational level of deficits in care, but no information to show that related neglect of consumers has been identified with appropriate and timely response.

There are organisational policies and procedures to support consumer well-being. However, these have not been implemented effectively at the service. Consumers have not been and are not being assisted with services and supports which optimise their independence, health, well-being and quality of life as documented in Standard 4. There has not been a major focus on consumer well-being through the results of quality assurance monitoring processes for oversight and nor do the partners in excellence committee meeting minutes feature this.

There are organisational policies and procedures about managing and preventing consumer incidents. However, these have not been implemented effectively at the service. There is some awareness at organisational level of deficits in relation to consumer incident reporting and management. However, corrective actions have not mitigated the risks sufficiently or in a timely manner.

In summary, it was not demonstrated the organisation has an effective risk management framework. There has not been effective management of high impact high prevalence risks associated with the care of consumers; the identification and management of abuse and neglect; supporting consumers to live the best life they can; or managing and preventing incidents.

The organisation has a documented clinical governance framework reflecting the national model clinical governance framework from the Australian Commission on Safety and Quality in Healthcare and the 6 pillars of clinical governance. This framework has not been fully implemented at the service.

Safe and quality care and services have not been provided to consumers at the service. Drawing on the 6 pillars, there has been some awareness of this at organisational level due to monitoring of effectiveness in clinical performance. There have been plans in keeping with safety and quality improvement systems. However, the plans have not led to sufficient and timely improvements.

There is organisational policy and procedure about antimicrobial stewardship (AMS), however it has not been tailored to suit the organisation. As well as continuing to include prompts for ‘Organisation Name’, it refers to an AMS program, monitoring antibiotic use and a monthly and quarterly KPI [key performance indicator] sheet. The latter is to be discussed at relevant meetings such as the quarterly infection control committee, including to ensure the CEO/director is aware of the outcomes of the AMS program.

A comprehensive AMS program was not evident in practice. The organisation has monthly clinical indicator reports, which includes data, trending and analysis about infection rates but not about indicators of AMS performance. Minutes of a MAC meeting from January 2023 did not show any data tabled about service performance in relation to AMS.

There are organisational policies and procedures about minimising the use of restraint. Restraint use with consumers at the service has been minimised as advised by the Facility Manager during the entry meeting and evident in review of the service’s psychotropic medication register and consumer care and service records.

There are organisational policies and procedures providing management and staff with guidance regarding the practice of open disclosure. Open disclosure has been implemented at the service in relation to feedback and complaints, however, it has not been implemented in relation to consumer incidents.

Consumer incident reports and progress notes show that the consumer’s representative is informed of an incident, but not that information is provided about how the incident occurred and/or actions to prevent recurrence. This in the main is due to a lack of investigation to enable this but may also be due to a lack of staff understanding about open disclosure.

Review of the partners in excellence committee meeting minutes shows there is organisational oversight of feedback and complaints and of consumer incidents, but not of related open disclosure.

In summary, a clinical governance framework has not been fully implemented and is not effective. Clinical governance has been demonstrated in relation to restraint minimisation. Clinical governance has not been demonstrated in relation to AMS or open disclosure as it relates to consumer incidents.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement and evidence of actions already implemented. The provider submitted the organisation’s one-page strategic plan, partners in excellence committee meeting minutes, the diversity and inclusion policy, risks discussed at governance meetings, clinical risk register, AMS policy and procedure and evidence of training in sirs and education on accessing the e-suite of policies and procedures. The provider has committed to organising a full mediation audit and employing a 24/7 Registered Nurse for clinical oversight and Risk management. A clinical Nurse Manager has commenced at the service on 26 June 2023 and will be supported by the Nurse Advisor and head office clinical team.

I acknowledge the immediate actions that the approved provider has committed to, however as some of the completion dates are end of August to end of September, it will take some time for these policies, procedure and actions to reflect that the organisation has effective oversight at the service.

I find that the approved provider is Non-compliant with requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e).

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