Villa Dalmacia Aged Care Facility

Performance Report

27 Gorham Way
SPEARWOOD WA 6163
Phone number: 08 9418 5222

**Commission ID:** 7234

**Provider name:** Villa Dalmacia Association Inc

**Site Audit date:** 29 March 2022 to 31 March 2022

**Date of Performance Report:** 9 June 2022

# Performance report prepared by

Alice Redden, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 3 June 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

Consumers and representatives said their cultural identities are respected and their needs met. Consumers reported they are supported to maintain their relationships, including intimate relationships, and said staff know what is important to them. Consumers and representatives confirmed consumers exercise choice and control over their care and reported they receive information in a timely manner, to support decision-making.

The service’s consumer cohort is largely of Southern European background, with many consumers speaking Italian and Croatian, as well as English. The service has established processes to identify and record cultural and language needs and preferences, which are included in care plans. Information about religious and spiritual needs are also recorded, along with cultural activities of choice. Consumers who take risks are supported to understand and manage those risks. Consumers said staff respect their privacy.

The service demonstrated information is provided to consumers in an accessible way, in various languages. Most staff at the service can speak a language other than English and converse with consumers in their native languages. Information is displayed in English, Italian and Croatian and the service reported they engage professional interpreters for reviews and for end of life planning. Significant days celebrated at the service include Croatian Day, Italian Day, Orthodox Easter and ANZAC Day.

Staff used respectful and caring language about consumers. Interviewed staff knew the language, cultural and religious needs, as well as daily care preferences, of sampled consumers. Staff understood how the service’s assessment process identifies and records consumer care needs and preferences, and they knew the risks taken by sampled consumers. Staff described the practical ways they respect consumer privacy.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Non-compliance is in relation to Requirement 2(3)(a). Reasons for my decision have been outlined in the relevant Requirement below.

Care plans of sampled consumers contained information about their personal and clinical care needs and preferences, as well as evidence of advanced care planning and end of life planning. Consumers and representatives confirmed the service provides timely opportunities for end of life discussions.

Care plans documented involvement of other organisations, individuals and providers, including dementia support services, dieticians, allied health professionals and Medical Officers. Consumers and representatives confirmed they are involved in assessment and planning processes on an ongoing basis, while staff outlined how the service includes consumers, representatives and others in planning and assessment, including through care conferences, telephone and email. Staff described, and care planning documentation confirmed, that changes or recommendations made by external providers, individuals and organisations are recorded in consumer care plans.

The service communicates the outcomes of assessment and planning to consumers and their representatives through direct discussions, phone calls and emails. Consumer representatives were aware of consumer care plans and that they could request access. Care plans contained evidence of regular consultations with representatives and other professionals involved in care and were found to be available to staff and visiting health professionals through the electronic care management system. Staff confirmed they learn of changes in consumer requirements through verbal and written handovers, the electronic care management system (ECMS) and progress notes. Most consumer care plans sampled contained evidence of scheduled reviews and reviews in response to incidents or changes in consumer circumstances.

## Assessment of Standard 2 Requirements*.*

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

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

Although the Assessment Team found the service has a framework in place to assess, record and plan consumers’ clinical care needs, they found assessment and planning, including the consideration of risks, does not consistently inform the delivery of safe and effective care and services. Relevant (summarised) evidence presented under this and other Requirements included:

* Consumer A had a pressure injury and documentation review suggested staff did not review and dress the wound as regularly as required in the wound care plan. Wound dimensions and characteristics were not recorded. When raised with management, the clinical care coordinator advised staff change the wound dressings but do not document it and advised a wound specialist would be retained to provide education on wound care and documenting.
* Sampled files contained initial, but not ongoing pain assessments. Pain levels were not recorded by staff for Consumers A, C and D.
* Although initial nutrition and hydration assessments, and weight charting were completed for Consumer B, who has a daily fluid restriction of 1.5L, their fluid intake was not monitored and/or not recorded.
* Consumer E lives with diabetes and is at higher risk of long-term complications. The Medical Officer (MO) directed twice daily Blood Glucose Levels (BGL) checks, however the Assessment Team found these were not monitored twice daily as required, on 3 days in a recent 12-day sample period.

Other examples of non-compliance put forth by the Assessment Team were not relevant to my decision and have not been included here. The remaining Assessment Team evidence demonstrated compliance.

In their response, the Approved Provider acknowledged some deficits and clarified some inaccurate evidence in the Assessment Team’s report in relation to one consumer’s wound assessment and another consumer’s catheter output monitoring. Therefore, I have not considered this information in my finding.

The response gave further information regarding Consumer A comorbidities and risk factors which, they argued, prevented their wounds from healing. The response included evidence which confirmed wound review and dressing changes either were not documented or did not occur as frequently as required and wound descriptions were lacking. The response did not include evidence staff measured the consumer’s pain or monitored the effect of pain management strategies used on an ongoing basis, despite the consumer having known chronic conditions causing them pain. The Approved Provider acknowledged the service had failed to commence pain charts for the consumer.

The response acknowledged deficits in Consumer C’s pain management and failures to follow the pain management policy. While a pain assessment had been completed for the consumer prior to the Site Audit, it had not resulted in changes to the care plan. There was also no evidence staff completed ongoing evaluation of the consumer’s pain intensity or that they monitored the effectiveness of pain management strategies used, despite the consumer’s recent history of falls.

The response outlined that Consumer D had experienced three falls and conceded that there were no pain assessments completed after the first two but argued there had been a pain assessment following the third fall. However, evidence attached to the response showed the third fall occurred well after the Site Audit, so does not demonstrate the service was compliant with this Requirement at the time of audit.

The response argued the service has prevented fluid overload in Consumer B and presented evidence to confirm that. However, the response did not provide evidence staff were documenting the consumer’s fluids. I accept the service may have prevented fluid overload, and as a result I did not consider the Assessment Team’s evidence in Requirement 3(a) (safe and effective personal and clinical care). However, the lack of fluid recording is relevant to this Requirement, as it demonstrates a lack of planning in the consumer’s care and a failure to take basic steps to mitigate their risk of fluid overload.

The response also clarified that Consumer E’s BGL recording occurred twice daily as required on 2 of the 3 days mentioned by the Assessment Team, but the handwritten records had not been entered into the ECMS. On 1 of the 3 days, only one of the checks occurred.

The Approved Provider also provided other information and evidence, which was not relevant to my decision and has not been outlined here.

The response contained an improvement plan, which included planned and implemented actions to address the deficits in pain management and documentation. Actions include a pain assessment audit of all consumers, review of the pain management policy and creation of a pain assessment flowchart to guide staff practice, with further clinical education planned for staff.

I acknowledge the service has implemented actions to address the deficits identified by the Assessment Team. However, at the time of the site audit the service did not have an effective system to ensure assessment and planning, including consideration of risks, was used to inform delivery of safe and effective care.

I am satisfied there was either inconsistent review and dressing of Consumer A’s pressure wound or reviews and dressings occurred but were not documented. I find that when reviews of the wound did occur, there was insufficient descriptive information about the dimensions and characteristics of the injury, to inform ongoing wound care. These deficits reflect an overall lack of planning and assessment in relation to the consumer’s wound care and demonstrates non-compliance with this Requirement.

I am satisfied the service also had deficits in assessment and planning for pain management. I find that the service did not always monitor and evaluate consumer pain and management strategies on an ongoing basis and after falls, or that the service completed those tasks but failed to properly document it. Both scenarios represent a failure to properly assess and plan for the ongoing delivery of safe and effective pain management for those consumers.

I have also considered the service’s failure to properly document Consumer E’s BGL checks in the service’s ECMS, and the gap in practice relating to the missed check, and find it reflects that the results of assessment and planning do not always inform service delivery.

Finally, I am satisfied there were deficits in assessment and planning in relation to monitoring and recording of one consumer’s fluid balances. By failing to record their fluid balance, the service did not sufficiently manage risk of fluid overload by ensuring all staff could easily access information needed to inform decision-making around fluid intake and deliver safe and effective care to that consumer.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Non-compliance is in relation to Requirements (3)(b), (3)(e), and (3)(g). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirements 3(a), (3)(d) and 3(f) not met. However, my findings differ from the recommendations and I find these Requirements Compliant. Reasons for the findings are detailed in the relevant Requirements below.

The service has established policies and procedures relating to end of life and advanced care planning. The service demonstrated they meet the needs, goals and preferences of consumers nearing the end of life, with consumers’ dignity preserved. Care plans contained instructions for end of life care, resuscitation and comfort requirements. Staff described how care delivery changes when consumers reach end of life and outlined the comfort-maximising strategies commonly employed at the service. Staff knew how to access consumers’ end of life plans and preferences. End of life preferences and plans are reviewed regularly and in response to consumer deterioration.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service generally provides safe and effective personal and clinical care, however found inadequate staffing levels at times placed consumers at risk of receiving care which is not best practice. Relevant (summarised) evidence included:

* Evidence regarding deficits in Consumer A’s wound care and pain charting, as outlined in Requirement 2 (3)(a).
* Staff did not always follow instructions to seek MO instruction before administering Consumer A’s twice daily blood pressure medication when the consumer had low blood pressure. Staff inconsistently recorded the consumer’s oxygen, blood pressure and pulse.
* Consumer B’s diuretic medication was given on several occasions, without their blood pressure being recorded first, as per medical directive. There was inconsistent application of care plan instructions, with staff administering the diuretic when there were readings of 100/60, while others did not.
* Consumer B also experiences shortness of breath and fatigue upon exertion. Staff did not always document Consumer B’s oxygen saturation readings before supporting them to mobilise, as required. Staff also did not record if they had provided oxygen to the consumer when their saturation fell below a certain level, as required.
* Consumer E’s BGLs were not checked as consistently as required, as outlined in Requirement 2 (3)(a).
* Consumers B’s daily fluid intakes were not recorded, as previously outlined in Requirement 2 (3)(a).
* The Assessment Team found care planning for falls risk and falls prevention was appropriate, however registered staff did not always follow the policy and procedures on neurovascular observations after falls, with two consumers not being observed every 15 minutes in the first hour after a fall.
* Consumer A’s representative was satisfied with care provided at the service overall but said that staff do not quickly change a wound dressing which gets wet when the consumer eats.
* A care staff member said at times they cannot attend to showers for all consumers but would provide some form of hygiene assistance as an alternative.
* The Chief Executive Officer expressed confidence in the registered staff at the service and confirmed they are considering hiring more registered nurses as existing ones are ‘thinly spread.’

Some evidence was not relevant to this Requirement and has been considered in relation to Requirement 2 (3) (a) instead. The remaining evidence put forth by the Assessment Team reflected compliance with this Requirement.

In their response, the Approved Provider took issue with some of the Assessment Team’s findings but also acknowledged some identified deficits. Where the response clarified inaccurate evidence in the Assessment Team’s report, I have not considered that information in my finding.

The response contained some clarifying evidence concerning pain management for Consumer A (refer to) Requirement 2 (3)(a), but evidence provided also showed that the wound dressing which gets wet when the consumer eats was not always changed as frequently as required in the wound care plan.

The response also outlined that at the time of Site Audit, Consumer A was admitted for end of life comfort care and symptomatic treatment of easily reversible causes only. Evidence provided in the response did not demonstrate that staff called for medical advice on every occasion they were required to, however progress notes included with the response indicates a lack of clear instructions and planning in relation to blood pressure monitoring. Evidence did not demonstrate vitals were checked as consistently as required but did show ongoing monitoring and review of the consumer after their admission and a referral to an MO for the consumer’s blood pressure medication, prior to the Site Audit. After the Site Audit, an MO directive was given to cease the consumer’s blood pressure medication and twice daily vitals monitoring.

The response did not acknowledge or address evidence from representative and staff interviews, or evidence about deficits in the management of Consumer B’s diuretic medication or their oxygen saturation levels prior to mobilising. For details of the Approved Provider’s response to evidence about Consumer E’s BGL monitoring, refer to Requirement 2(3)(a).

The response acknowledged findings that neurological observations were not always completed after falls and provided a plan for improvement to address the deficits, featuring planned and implemented actions including a fall incident audit and audit of clinical staff compliance with falls management policy.

After weighing the Assessment Team’s evidence with the Approved Provider’s response, I have disagreed with the Assessment Team’s recommendation and find the service compliant with this Requirement, for the following reasons.

I find the care planning documents for Consumer A contained ambiguous and contradictory directives. The evidence did not show the care plan was completely followed by the service, but it is also unclear what the plan for the consumer’s blood pressure medication was. There was no identified impact to the consumer because of how the medication was managed. Similarly, despite the identified gaps in wound care, there was no identified impact to the consumer and I have placed significant weight on the representative’s overall satisfaction with care provided to Consumer A. On balance, there is insufficient evidence to find the service delivered unsafe or ineffective care to the consumer, however there were gaps in care and lapses in documentation and planning during the period. As such, the wound care and pain management evidence is more relevant to Requirements 2 (3)(a) and 3(3)(e), where I have considered it instead.

I am satisfied that deficits in the management of Consumer B’s diuretic medication indicate non-compliance and that there were several days when the consumer received their diuretic medication without having their blood pressure checked. I am also satisfied there was inconsistent understanding when to administer the medication. However, there was no identified impact to the consumer because of these errors, and as a result, I have not given this evidence strong weight.

I am also satisfied the service did not ensure Consumer E’s BGLs were checked twice a day every day, however, the evidence demonstrated only one missed reading, which reflects a gap in either practice or documentation, with no identified impact to the consumer. The gap does not evidence unsafe or ineffective diabetes management.

I have not considered the deficits in post-falls neurological observations identified by the Assessment Team and acknowledged by the Approved Provider, as there was no evidence of any consumer impact as a result of and most evidence related to falls management showed it to be safe and effective. I have instead considered this evidence in Requirement 3(3)(b), where it is more relevant as an example of failure to manage high impact risks associated with the care of each consumer.

In relation to staff and CEO interview evidence, I note care staff confirmed they were able to provide basic hygiene care even when pressured for time and there were no identified impacts to consumers as a result. As staff and CEO interview evidence is more relevant to sufficiency of workforce numbers, I have considered this evidence in Requirement 7 (3)(a), where it is more relevant.

As the majority of evidence of non-compliance put forth by the Assessment Team was more relevant to other Requirements, was not representative of systemic failures in personal and clinical care and did not result in any identified detrimental impact to consumers, I find this Requirement is Compliant. I also note that most evidence included under Requirement 3 (3)(a) demonstrated the service is providing safe and effective personal and clinical care.

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

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

The Assessment Team found deficits in the service’s management of high impact and high prevalence risks. Relevant (summarised) evidence presented in this and other Requirements included:

* Although the service uses pain assessments, monitoring charts and pain scales, as previously outlined in Requirement 2 (3)(a), Consumers A, C and D did not have their ongoing pain levels assessed and recorded, despite their experiencing ongoing pain and/or a recent history of falls.
* Registered staff at the service did not always follow post-falls neurological observations policies and procedures, as previously outlined in Requirement 3 (3)(a).
* The Assessment Team also referred to care staff feedback regarding occasional instances when they are unable to attend to showers. This has been considered in Requirement 7 (3)(a) where it is more relevant.

Other pain management and representative interview evidence cited by the Assessment Team was not relevant to my decision and has not been included here.

The remaining evidence put forth in the Site Audit Report reflected compliance and indicated the service effectively manages consumer risks related to weight loss.

In their response, the Approved Provider acknowledged deficits related to pain charting for Consumers A and C and the failure to complete pain charting after two falls for Consumer D. The response included a plan for improvement with steps to address these deficits, as previously outlined in Requirement 2 (3)(a).

The response acknowledged the deficits in falls management identified by the Assessment Team and provided results of a spot check audit completed in response to the findings, which found additional deficits in fall incident management, including failure to have Falls Risk Assessment Tools (FRATs) reviewed after a fall for two consumers, the lack of a mobility assessment for one consumer who fell and failure to complete neurological observations every 15 minutes after a fall, for two consumers. The improvement plan included with the response sets out planned and implemented actions to address these deficits including a review of the service falls prevention policy, creation of a falls management flowchart for staff and planned education on the process for clinical, allied and medical officer staff.

I acknowledge the service is taking appropriate steps to address the deficits. However, at the time of Site Audit, the service was not effectively managing the high impact and high prevalence risks for each consumer.

I accept there were failures to commence and maintain pain charts for two sampled consumers who were known to experience pain and no pain assessments were completed following falls for a third consumer. Risks of chronic and ongoing pain, as well as emergent pain following falls were therefore, not managed effectively.

The service also did not effectively manage the risk of falls occurring by failing to ensure one consumer had a mobility assessment plan in place. Additionally, the service did not properly manage the risk of injuries, by failing to ensure two consumers had full neurological observations completed after falls. Lastly, the service did not take adequate steps to mitigate the risk of further falls in two consumers, by failing to ensure their FRATs were reviewed by a physiotherapist after they experienced falls.

In reaching my decision, I also find that other risks associated with wound care in Consumer A were not managed effectively, as a result of repeated failures by staff to complete and/or document wound reviews and dressing changes for the consumer’s sacral area pressure injury.

I find the service, by failing to record Consumer B’s fluid balance, did not effectively manage the risk of fluid overload in that consumer. The service also failed to effectively manage that consumer’s known risks of breathlessness and fatigue, by failing to consistently measure and/ or record the consumer’s oxygen saturation readings before supporting them to mobilise. Lastly, I find that Consumer B’s known risk of low blood pressure was not effectively managed, as they were given their diuretic medication on several occasions, when their blood pressure was not measured and/or recorded.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

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

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

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

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

The Assessment Team found the service did not always recognise and respond in a timely manner to deterioration or change in a consumer’s health, function, capacity and condition. They considered that while most sampled care plans did evidence timely response to change and deterioration, some showed staff do not always follow policy and procedure. Relevant summarised evidence included:

* As outlined in Requirement (3)(a), staff did not always follow medical directives to seek MO review in response to Consumer A’s low blood pressure readings, prior to administering blood pressure lowering medication.

The remaining evidence put forth by the Assessment Team reflected compliance with the Requirement.

In their response, the Approved Provider gave evidence to demonstrate their overall response to Consumer A’s deterioration within the constraints of the Advanced Care Plan and wishes of the consumer and their representative. Refer to Requirements 2 (3)(a) and 3(3)(a) for further detail regarding the Approved Provider’s response.

Other evidence included in the response was not relevant to my decision and has not been outlined here.

Having regard to the evidence put forth by the Assessment Team and the Approved Provider’s response, I have disagreed with the Assessment Team and instead find the service is Compliant with this Requirement. I find the management of Consumer A’s blood pressure medication reflected deficits in assessment and planning in the wider context of a newly admitted consumer who was receiving palliative care. The service provided evidence to show they were actively recognising and responding to the consumer’s overall deterioration within the constraints of the Advanced Care Plan and representative’s express wishes that the consumer was for comfort care only. I have previously reached a finding of non-compliance on the basis of the contradictory and unclear care plan instructions regarding the consumer’s blood pressure medication. The evidence does not indicate a failure to recognise and respond to consumer deterioration. As there was no other evidence put forth by the Assessment Team to support their recommendation, I disagree with their recommendation and find the service is Compliant.

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

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

The Assessment Team found the service failed to accurately and consistently document consumer information in care planning documentation. Relevant (summarised) evidence put forth in this and other Requirements included:

* Staff failed to accurately and consistently document wound characteristics, reviews and dressing changes for Consumer A, as previously outlined in Requirements 2(3)(a) and 3(3)(a). Other wound care plans for unidentified consumers were also found to be lacking in descriptive detail.
* Staff failed to record consumer fluid intake for Consumer B, as previously outlined in Requirements 2(3)(a) and 3(3)(a).
* Consumer E’s BGL checks were not consistently recorded as outlined in Requirement 3(3)(a).
* Although the service uses pain assessments, monitoring charts and pain scales, as previously outlined in Requirement 2 (3)(a), Consumers A, C and D did not have pain charts in place.

Other evidence put forth by the Assessment Team was not relevant to my decision and has not been included here. The remaining examples put forth by the Assessment Team reflected compliance with the Requirement.

In their response, the Approved Provider acknowledged some deficits identified by the Assessment Team but took issue with others, providing clarifying information and evidence in relation to named consumers. Please refer to response details which have already been outlined in Requirements 2(3)(a) and 3(3)(a).

Having had regard to the Assessment Team’s evidence and the Approved Provider’s response, I find the service is Non-compliant with this Requirement, because important information about consumers’ condition and needs was not effectively communicated in consumer care plans, which are key sources of information and relied upon by staff and others who share care.

In relation to Consumer A, the response did not demonstrate that wound dimensions and characteristics were consistently documented to support continuity of care between staff and others. The response did not acknowledge the deficits in wound care documentation or any gaps in wound care provided, and no improvements in relation to wound care documentation were included in improvement action plans provided. Processes for communicating the frequency of wound care and wound characteristics were not effective, undermining ability of staff to provide consistent and coordinated wound care.

No evidence was provided to show that staff monitored and recorded Consumer B’s fluids, demonstrating a failure to ensure accurate and updated information about consumer needs and conditions was communicated to staff providing care.

I have taken the Approved Provider’s response into account regarding Consumer E’s BGL checks and accept that the BGLs were recorded but were not entered into the service ECMS. This raises concerns about the effectiveness of the communication and record-keeping processes at the service, however, as the information was documented somewhere, I have given this evidence less weight.

I find that the service did not always use pain charts to monitor and evaluate consumer pain and management strategies, including after falls, which detracts from consumer safety by reducing the capacity of staff to deliver coordinated and consistent care and monitoring of consumers who have a heightened risk of injury following a fall.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

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

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

The Assessment Team considered the service was Non-compliant with this Requirement, for previously described deficiencies in responding to a consumer’s low blood pressure readings. Relevant (summarised) evidence included:

* Staff did not always seek Medical Officer advice before giving blood pressure lowering medication to Consumer A, when they had low readings.

The remaining evidence put forth by the Assessment Team reflected compliance with this Requirement.

The Approved Provider gave evidence to demonstrate their overall response to Consumer A’s deterioration within the constraints of the advanced care plan and express wishes of the consumer and their representative. Refer to Requirements 2 (3)(a) and 3(3)(a) for further detail.

Having regard to the evidence in the Site Audit Report and the Approved Provider’s response, I have disagreed with the Assessment Team and find the service is Compliant with this Requirement. I accept staff did not always seek MO advice prior to giving blood pressure lowering medication to Consumer A, however, as outlined in Requirement 2(3)(a), consider this reflected an overall lack of clear care planning in relation to the consumer’s medication and vital signs monitoring. I do not consider this is sufficient to find the service non-compliant with this Requirement, as the evidence showed the service has a network of individuals and organisations who they actively refer consumers to.

Most of the evidence highlighted by the Assessment Team demonstrated compliance with this Requirement. Sampled care plans evidenced timely and appropriate referrals to range of individuals, organisations and other providers, including dementia support services, medical specialists and allied health professionals. Consumer and representative feedback confirmed consumers get access to the professionals and services they require, including for example dieticians, physiotherapists and Medical Officers.

Based on the summarised evidence above, I find the service Compliant with this Requirement.

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team considered the service was not compliant with this Requirement owing to onsite observations of poor hand hygiene and PPC usage. Relevant (summarised) evidence included:

* An EN was observed pulling their mask down to speak to consumers and not washing their hands between each consumer they gave medication to. The medication trolley did not have hand sanitiser on it.
* A care staff member was delivering food and retrieving dirty dishes and did not sanitise their hands between consumers.
* Hand hygiene facilities were observed throughout the service but not in consumer rooms.

When the deficits were raised with management, they gave undertakings to follow up with the relevant staff.

The remaining evidence put forth by the Assessment Team reflected compliance with the Requirement.

In their response, the Approved Provider supplied evidence of an internal hand hygiene audit completed prior to the Site Audit, which found 100% of staff were compliant with hand hygiene requirements. They also reported the service IPC Lead had provided the identified staff members with additional hand hygiene training.

Having had regard to the evidence put forth by the Assessment Team and the Approved Provider’s response, I find the service Non-compliant with this Requirement, for the reasons outlined below.

Although the service has established policies and procedures relating to infection control and prevention and antimicrobial stewardship, which they monitor through internal audits and spot checks, onsite observations showed that staff practice is not in compliance with infection and prevention control guidelines in relation to hand hygiene and PPE usage. A staff member was observed touching their mask to remove it, while in close proximity to consumers, placing them at risk of exposure to potentially infectious air borne droplets. The same staff member, and another, did not practice hand hygiene in between consumers, increasing the risk of infection for those consumers through indirect contact with contaminated surfaces and objects. That the service’s existing auditing and spot check regime did not identify any deficiencies in staff practice raises concerns about its effectiveness.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

Consumers and representatives said they feel supported to do things they enjoy and confirmed they are engaged in developing the service’s lifestyle program. Sampled consumers reported staff to be kind, caring and approachable and confirmed their relationships and connections are supported. Representatives said they feel welcome at the service. Interviewed consumers generally felt staff at the service know their needs and preferences for daily living. Consumers and representatives were satisfied with the quality and quantity of food served and equipment used to assist consumers in their daily living was reported to be in good condition, clean and maintained.

The service has established systems to identify consumer interests, spiritual or religious requirements and their favourite pass-times. Information about consumers’ cultural, spiritual and lifestyle preferences and information to support them engaging with activities is communicated in care plans. Care plans contained consumers’ life histories and interests and the activities they want to participate in at the service and in the community. Through the service’s ECMS, care plans are accessible by staff and other visiting professionals to facilitate shared care. Handovers are also used to communicate information about changes in care needs. Consumer dietary requirements are recorded in care planning documentation and are on display in the service kitchens. Kitchens, lifestyle, laundry and catering equipment were observed to be clean, well-organised and maintained.

Staff knew what is important to sampled consumers and confirmed they are encouraged and supported to spend time talking to consumers individually every morning. Interviewed staff outlined how they encourage consumers to participate in the wider community. Staff confirmed a range of external organisations, individuals and services are involved in the lifestyle program, including priests, volunteer organisations, sporting programs, day-centres and private businesses. Staff had a shared understanding of how to access information about consumer needs and preferences and described how changes in care needs and preferences are communicated.

The Assessment Team observed consumers engaged in a variety of activities during the Site Audit and viewed evidence of a wide range of past outings, games, classes and group activities including, for example, limousine rides, a petting zoo and a wine tour. Consumer feedback about the lifestyle program was positive.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

Consumers and representatives said consumers feel safe and comfortable at the service, which they described as homely. Consumers confirmed their rooms are well-serviced daily by cleaning staff and considered the service to be well-maintained and clean. While one consumer said they required a suitable wheelchair to allow them to move about service, they confirmed they were not impacted by the lack of one and said the service was enquiring about it.

The service is comprised of seven wings, two within a secure care unit. Communal lounges observed throughout the service were well-used by consumers and visitors, and the service was well-lit, clean and maintained. Uncluttered corridors and the layout of the service promote free movement and consumer independence. However, it was noted that consumers in the secure care unit did not have free access to outside areas. Furniture, fittings and equipment was observed to be safe, clean and suitable for use. The service has scheduled and reactive maintenance programs with no outstanding or overdue items, and a schedule for cleaning staff to follow.

Staff described how they engaged with consumers and visitors to make them feel at home in the service and management said that a recent audit showed 100% consumer satisfaction with the service environment. Staff confirmed maintenance requests are attended to quickly and outlined how requests are made. While staff could describe how shared equipment is sanitised between uses, one staff member was unsure if this occurred consistently for larger pieces of equipment, such as hoists. Maintenance staff and management described how the service environment is monitored through feedback, audits and daily visual inspections.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

Consumers and representatives confirmed they felt comfortable and safe making complaints or giving feedback at the service. Most consumers and representatives knew about external complaints mechanisms and advocacy services, however considered that they were unlikely to use them as action is taken in response to feedback at the service. Consumers gave examples of complaints and feedback they had given in the past which the service responded to in a satisfactory manner.

The service has an effective complaints and feedback system that records complaints and feedback from all sources, including those raised through feedback forms, surveys and consumer meetings. These are entered on the complaints and feedback register and monitored through any ensuing investigation until action is taken and feedback given to complainants. The service has a low number of consumer complaints, however it demonstrated that previous complaints have resulted in service-level changes being made, reflecting that feedback is monitored and used to drive improvement in care and services.

Staff said they were comfortable to raise their concerns with management and said they are routinely asked for feedback by management. Staff demonstrated understanding of the complaints handling process and described how they actively seek feedback from consumers and escalate concerns. Staff described supporting consumers to complete feedback forms or arrange assistance from others if requested by consumers. Although staff were not trained in open disclosure, they demonstrated practical use of its principles, including transparency and apologies when things go wrong. Management understood open disclosure terminology and confirmed formal training would be provided to staff in future.

The Assessment Team reviewed the complaints register, which confirmed the low number of complaints overall and showed complaints from all sources are captured and monitored to the point of closure. Recent audit results, viewed by the Assessment Team, showed high consumer satisfaction with the service’s handling of complaints and feedback. Information about translating and interpreter services, advocacy services and complaints processes is displayed throughout the service, in various languages.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Non-compliance is in relation to Requirement 7(3)(e). Reasons for my decision have been outlined in the relevant Requirement below.

The Assessment Team also recommended Requirement 7(a) not met. However, my finding differs from the recommendations and I find this Requirement Compliant. Reasons for the findings are detailed in the relevant Requirement below.

Consumers confirmed their overall satisfaction with staff and said interactions were positive, kind and respectful. Interviewed staff were familiar with the needs and communication requirements of consumers, whilst management confirmed they monitor consumer-staff interactions through observations and feedback from consumers and representatives. Interactions observed by the Assessment Team were consistently respectful and personable.

Consumers and representatives were satisfied with staff performance and said they have the skills needed to perform their roles effectively. The service has established systems and processes to ensure staff have relevant qualifications, registrations and experience, and worker screening checks are completed and monitored. The service has orientation and ongoing training requirements, with staff completing mandatory monthly and annual training.

Consumers considered staff have the skills and knowledge to ensure delivery of safe and effective care and services, while staff said they have access to the training they need to perform and grow in their role. The service identifies training opportunities by analysing incidents, clinical indicators, feedback and complaints. Training modules for staff are in line with the Quality Standards, however it was noted that staff have not yet received training in open disclosure or antimicrobial stewardship.

## Assessment of Standard 7 Requirements

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

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

The Assessment Team found the service does not always have a sufficient number and the right mix of staff deployed to enable the delivery of safe and quality care and services. Relevant (summarised) evidence included:

* Deficits relating to medication management, pain charting, fluid balance recording, oxygen saturation recording and missed neurovascular observations after falls, which have been previously outlined in Standards 2 and 3.
* Findings that the service does not regularly monitor and review call bell response times.
* A review of response times for a recent month showed 10 call bells took longer than 10 minutes to answer, with the rest being answered in under 4 minutes.
* Consumer feedback indicated there are times when consumers are required to wait for support, but that usually, bells are answered quickly.
* A representative considered the service can be short on personnel at times, but staff ‘do the best they can.’ The representative noted that staff no longer have time to ‘stop and chat’.
* Interviewed staff reported only occasional personnel shortages.
* The service uses agency staff when in house personnel cannot fill a shift, however there are times when agencies themselves cannot provide staff.
* The Clinical Care Coordinator will assist with care tasks and medications when care or registered staff are short.
* In the week prior to the Site Audit, there were two unfilled shifts at the service.
* Management and the CEO said they are ‘thinly spread’ with RNs at times and cannot give best practice care on the days when they are short of staff.
* A care staff member confirmed at times when they are unable to shower consumers due to short-staffing, they will still attend to consumer hygiene and are able to attend to consumer continence aids as well.

Other examples of non-compliance put forth by the Assessment Team were not relevant to my decision and have not been included here. The remaining evidence cited by the Assessment Team reflected compliance with this Requirement.

In their response, the Approved Provider acknowledged challenges in recruiting staff and outlined measures the service is taking to recruit new RNs, including paying incentives to staff for referring potential new hires and sponsoring an EN to study nursing at a local university.

Having regard to the evidence and information put forth in the Site Audit Report and the Approved Provider’s response, I disagree with the Assessment Team’s recommendation and find the service to be compliant with this Requirement, for the following reasons:

* Although the service did not have a practice of regularly monitoring call bell response times, response data indicates the clear majority of calls at the service are answered within 4 minutes.
* There are always RNs rostered on at the service.
* Although there was mixed consumer and representative feedback at interview, overall consumers considered their call bells are usually answered quickly. One representative who said they suspect that staff do not quickly change a wound dressing because of short-staffing also said they were very happy with their family member’s care overall. There was no identified impact to the consumer’s wound as a result of the inconsistent wound dressing changes. A second representative, who considered staff have less time to talk now then previously, also stated there had been no impact on their family member as a result of staffing issues.
* Although care staff reported some staffing shortages, no staff identified any risk or significant detrimental impact to consumers as a result. The one staff member who was quoted explicitly stated they have enough time to attend to continence aids and to provide some basic hygiene care, even when short-staffed.
* The Assessment Team’s recommendation relied heavily on evidence (in Requirement 3 (3)(a)) of gaps in medication management, pain charting, fluid balance recording, oxygen saturation recording and missed neurovascular observations after falls. Although the Team considered this evidence demonstrated the service does not provide each consumer with safe and effective personal and clinical care, I disagreed with their recommendation and instead found that Requirement Compliant, because most deficits identified by the Assessment Team related to gaps in documentation. Although some gaps in the personal and clinical care delivered were identified, there was no actual detrimental impact identified.
* I acknowledge the risks associated with the deficits in assessment and planning and documentation of care delivered and find that this may be a result of staffing issues experienced at the service. However, in their response, the Approved Provider confirmed a targeted recruitment drive is underway, and I find the service is taking concrete and creative steps to address recruitment challenges that are being experienced in the industry at present, and particularly in regional locations.

Having regard to the evidence, I find that on balance, there is insufficient evidence to demonstrate inadequate staff or incorrect mix of staff at the service. While there was a clear trend in interviews, none of those representatives, consumers or staff members identified any significant detrimental impact to consumers as a result of staffing issues. None raised concerns that consumers were at risk because of staff shortages. Call bell data reflects that rostering practices at the service are effective and the service uses an agency to fill unplanned leave shifts, when the agency itself has capacity to provide staff. As a result, I do not agree with the Assessment Team’s recommendation.

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

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

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

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

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

### Requirement 7(3)(d) Compliant

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

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

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

The Assessment Team found the organisation has an established performance monitoring and management framework in place. The documented framework monitors staff performance through staff, consumer and /or representative feedback as well as through performance appraisals. Organisational procedure requires that staff still in their probationary period have 3 monthly and 6 monthly performance appraisals, and following that, appraisals are carried out annually. However, the Assessment Team found the service was not compliant with this Requirement. Relevant summarised evidence included:

* Performance appraisals for staff who had been employed for four or more years were more than one year overdue. The service had however, prioritised performance monitoring and review for newer staff, whose appraisals were up to date.

The remaining evidence put forth by the Assessment Team reflected compliance with this Requirement.

In their response, the Approved Provider acknowledged that staff performance appraisals were overdue, and referred to their improvement action plan, which provided a time line for staff appraisals to be brought up to date.

I acknowledge the service has planned appropriate actions to address the deficits in performance monitoring. I also acknowledge the service has an organisational staff performance framework, supported by policies and procedures that require staff performance be reviewed annually. However, at the time of the site audit the service was not effectively monitoring the performance of staff and deficits in staff practice, particularly in relation to documentation, assessment and planning, were not being identified to ensure staff performance review and management occurred.

Based on the summarised evidence above I find the service Non-compliant with this Requirement.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Non-compliance is in relation to Requirements 8(3)(c) and 8(3)(d). Reasons for my decision have been outlined in the relevant Requirement below.

The Assessment Team also recommended Requirement 8 (3)(b) not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding is detailed in the relevant Requirement below.

The service demonstrated they engage consumers and representatives in the development, delivery and evaluation of care and services, with consumers confirming they have been supported to make changes in their care. The service invites participation through various mechanisms, including care and service plan reviews, surveys, consumer and representative meetings and quarterly consumer meetings that are chaired by the CEO.

The service has a clinical governance framework in place, with documented policies and/or procedures relating to antimicrobial stewardship, restrictive practices and open disclosure. Staff were able to demonstrate their practical understanding of the principles of antimicrobial stewardship, infection prevention and control, open disclosure, incident management and elder abuse, and confirmed they had received training on restrictive practices.

## Assessment of Standard 8 Requirements

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

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

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

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

### The Assessment Team found the governing body does not promote a culture of safe, inclusive and quality care and services whose delivery they are accountable for, as the service’s monthly clinical indicators and audit results were not used to improve service delivery. Relevant (summarised) evidence included:

* A pain management audit which may have showed poor consumer satisfaction with pain management at the service. The Assessment Team found no evidence the governing body was monitoring the service’s management of pain or taking steps to improve practice despite the results of the survey.
* The Assessment Team found no evidence the governing body was aware of deficits in practice they had identified in Requirement 3(3)(a) (personal and clinical care).

The remaining evidence put forth by the Assessment Team reflected compliance with this Requirement.

The response did not acknowledge or refute the audit findings, but instead referred to their improvement action plan, which includes actions to address identified deficits in pain management and falls management which have been previously outlined. Steps have been taken to commence implementing the improvement plan, and timeline for completion is included.

Having regard to the Assessment Team’s evidence and the response, I find that on balance, there is insufficient evidence to support their recommendation and instead find the service is Compliant with this Requirement. The results of the audit as presented in the Site Audit Report did not clearly indicate poor consumer satisfaction with pain management and there was insufficient evidence presented by the Assessment Team to support their recommendation of Non-compliance in Requirement 3(3)(a). Refer to that Requirement for further detail.

The Assessment Team did not provide evidence, in the form of governing body meeting minutes or interview evidence with governing body members, to substantiate their findings in this Requirement. I accept there were clear deficits in assessment, planning and documentation and there was some evidence of deficits in delivery of personal and clinical care. However, there was no evidence of detrimental impact to consumers as a result, suggesting the deficits may not have resulted in poor outcomes in terms of clinical indicators, key performance indicators or adverse events, which are reported to the governing body each month. There is no clear evidence that the governing body was unaware or not monitoring the service appropriately. Comments made by the CEO indicate the governing body was aware of nursing staff being “stretched thin” and efforts are being made to recruit new staff, evidencing that resources have been mobilised to improve service delivery by increasing staff numbers.

Based on the evidence and reasons summarised above, I find the service Compliant with this Requirement.

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

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

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

The Assessment Team found the service had effective organisation-wide governance systems relating to information management and financial governance. However, they found deficiencies in continuous improvement, workforce governance and regulatory compliance governance. Relevant (summarised) evidence included:

Continuous Improvement

* Although the service has a plan for continuous improvement, risks and deficits in clinical care, and the previously described pain audit results, were not included in it. No steps were taken to ensure pain management at the service improved, including through the use of pain charts.
* The Assessment Team considered there were deficiencies in clinical monitoring and oversight of the service as management and the governing body were not aware of the risks in clinical care identified by the Assessment Team (refer to Requirement 3 (3)(a)).

Regulatory Compliance

* The Assessment Team considered that clinical and care procedures were not reviewed based on consideration of changes in evidence-base and the service did not use updates from relevant entities such as this Commission or the Australian Commission on Safety and Quality in Health Care. Evidence cited by the team to support this finding included only that the service had not provided training in open disclosure and antimicrobial stewardship.

Workforce Governance

* Despite having established processes to assign roles, responsibilities and accountabilities, annual staff performance appraisals were overdue, as outlined in Requirement 7 (3)(d).

In their response, the Approved Provider acknowledged some deficits and took issue with others. The response acknowledged deficits in care identified by the Assessment Team and referred to the previously described action plan items to improve pain management and falls management. The response also contained evidence of actions taken and planned to address other deficits, including scheduled training on Open Disclosure and Antimicrobial Stewardship.

The response provided clarifying information and evidence which demonstrated that policies and procedures had been updated in line with the Quality Standards. It argued that the updated policies and procedures drew on reference material from the Commission and other relevant bodies and included policies and procedures on antimicrobial stewardship and open disclosure. Evidence was provided which demonstrated that staff had been supported with training to understand the updated policies and procedures.

Having regard to the Assessment Team’s evidence presented throughout the report, and the Approved Provider’s response, I have found the service is Non-compliant with this Requirement, for the following reasons.

I acknowledge the service has established governance systems in relation to workforce governance and human resources, continuous improvement and regulatory compliance. The service has supported staff with training to understand the policies and procedures. However, staff do not consistently follow the procedures and service management has not ensured staff practice aligns with expectations, particularly in regard to assessment and planning and documenting provision of personal and clinical cares tasks, such as fluid monitoring, pain levels and wound care. Continuous improvement logs did not identify these areas for improvement, raising concerns about clinical monitoring in the service. Human resources policy was not followed, and staff performance has not been formally evaluated according to schedule, as outlined in Requirement 7(3)(e).

I find the deficits in documentation, assessment and planning also indicate the lack of an effective system for managing information. Consumer information is not accurately gathered, assessed, documented or communicated, as has been outlined in Requirements 2(3)(a) and 3(3)(e). This has resulted in critical information not always being included in care plans, undermining staff capacity to provide continuity of care, including in relation to wound care, pain relief and provision of fluids. While detrimental impact to consumers as a result of these deficits was not identified, there is risk to consumers should these deficits not be addressed.

For the reasons outlined above, I find the service is Non-compliant with this requirement.

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

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

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

The Assessment Team found the service has effective risk management systems and practices relating to identifying and responding to abuse and neglect, supporting consumer quality of life and managing and preventing incidents. However, the Assessment Team found there are risks in how clinical care is delivered at the service, based on the clinical care deficits identified in relation to pain management, clinical deterioration, falls, fluid balance and wound management, which were outlined in Requirements 2(3)(a), 3 (3)(a) and 3(3)(b).

In their response, the Approved Provider acknowledged the deficits identified by the Assessment Team and provided evidence of actions taken and planned to address the deficits. Actions include the review of current policies, development of flowcharts to support staff to achieve better alignment with service policy and procedure and audits of service performance. It is noted however, that the improvement action plan supplied to the Commission did not contain any actions to improve the management and documentation of wound care at the service.

I acknowledge the steps the service is taking to address some of the deficits in management of high impact and high prevalence risks. However, at the time of the Site Audit, staff practice was not in alignment with service policy and procedure in relation to pain and falls management and there were several identified gaps in assessment, planning and the documentation of important clinical information. These gaps and deficits in practice create risks to consumers and it is not clear that the deficits were identified by the service’s own monitoring systems and service management. It is also not evident that the service is taking steps to address deficits in wound care as part of their response to the Site Audit findings.

For the reasons outlined above, I find the service Non-compliant with this Requirement.

### Requirement 8(3)(e) Compliant

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

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

# Areas for improvement

Standard 2 Ongoing assessment and planning with consumers

* Requirement (3)(a) Ensure assessments and plans are completed and accurate in line with the organisation’s procedures, including when new consumers are admitted or when consumer’s condition is changing. Ensure monitoring of assessments and plans is effective at identifying and rectifying deficits in assessments and plans, including relating to charting and recording of observations.

Standard 3 Personal care and clinical care

* Requirement (3)(b) Ensure high impact and high prevalence risks associated with the care of the consumer are managed effectively. Ensure risks associated with pressure injuries, falls, and pain are identified, and appropriate assessments and strategies are implemented to manage and minimise the risks, and those strategies are recorded. Ensure monitoring of staff practice is effective at ensuring consumers risks are being managed effectively.
* Requirement (3)(e) Ensure information about the consumer’s condition is documented, recorded and communicated effectively to the staff providing care to the consumer.
* Requirement (3)(g) Ensure staff PPE and hand hygiene usage is in line with infection control management procedures and guidelines.

Standard 7 Human resources

* Requirement (3)(e) Ensure ongoing monitoring and review of staff practice and performance occurs to identify deficits, areas for improvement and opportunities for further training and support. Ensure staff performance appraisals are brought up to date and remain up to date.

Standard 8 Organisational governance

* Requirement (3)(c) Ensure the organisational governance systems of information management, continuous improvement, workforce governance and regulatory compliance are effectively implemented and monitored at the service.
* Requirement (3)(d) Ensure staff practice aligns with the organisation’s policies and procedures in relation to effectively managing consumer’s high impact and high prevalence risks and supporting consumers to live the best life they can.