Performance

Report

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| Name: | Wallsend Aged Care Facility |
| Commission ID: | 1500 |
| Address: | 10 Longworth Avenue (HNELHD Campus), WALLSEND, New South Wales, 2287 |
| Activity type: | Site Audit |
| Activity date: | 30 October 2023 to 1 November 2023 |
| Performance report date: | 18 December 2023 |
| Service included in this assessment: | Provider: 1640 NSW State Government (NSW Ministry of Health)  Service: 592 Wallsend Aged Care Facility |

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 Wallsend Aged Care Facility (**the service**) has been prepared by Katherine Richards, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management, and others.
* the provider’s response to the assessment team’s report received 1 December 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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 provider ensures staff use best practice behaviour support strategies to support consumers living with changed behaviours. The provider ensures restrictive practices are used in full compliance with all legal requirements. The service ensures staff deliver care and services in a manner that protects consumer dignity.
* **Requirement 2(3)(a):** The provider ensures assessment and planning, including consideration of risks relating to pain, bowels, sleep, hygiene, skin care. changed behaviours and use of restrictive practices, is used to inform care and services delivered.
* **Requirement 2(3)(b):** The provider ensures assessment and planning identifies and addresses consumers’ current needs, goals and preferences, and consumers with end of life and advanced care plans are clearly identifiable in care plans. The provider ensures all care planning documentation, included documents used in handovers, is internally consistent, accurate and reflect the current assessed needs of each consumer.
* **Requirement 2(3)(c):** The provider ensures consumers and representatives have genuine and ongoing partnership in assessment and planning processes and are provided with information about the consumer’s condition and any other relevant information, in a timely manner. The provider ensures staff are supported to understand the role and purpose of public guardians and public trustees. The provider ensures care and services are informed by recommendations and input from other services, organisations, and individuals.
* **Requirement 2(3)(e):** The provider ensures care and services are regularly reviewed for effectiveness, care plans are updated on a routine basis and when consumer needs or circumstances change, or incidents occur.
* **Requirement 3(3)(a):** The provider ensures each consumer gets safe and effective personal care and clinical care which is in line with best practice and consumer needs. The provider monitors staff practice in relation to restrictive practices, wound care, skin care, and pain to ensure personal and clinical care delivered is in line with best practice and the service’s procedures to optimise the wellbeing of the consumer.
* **Requirement 3(3)(b)**: The provider ensures high impact and high prevalence risks associated with the care of the consumer are managed effectively. Risks associated with pressure injuries, falls, behaviours and pain are identified, and appropriate assessments and strategies are implemented to manage and minimise the risks. The provider ensures monitoring of staff practice to ensure consumers risks are being effectively managed.
* **Requirement 3(3)(e):** The provider ensures information about the consumer’s condition is accurately documented and recorded, and consistent information is communicated effectively to the staff providing care to the consumer.
* **Requirement 3(3)(f):** The provider ensures referrals to relevant professionals are made in a timely manner in line with consumer needs.
* **Requirement 3(3)(g):** The provider ensures staff practice and actions to manage consumer infections is in line with infection control management procedures and guidelines.
* **Requirement 4(3)(b):** The provider ensures each consumer receives services and supports that promote and support the consumer’s emotional, spiritual, and psychological wellbeing. Ensure consumer’s specific emotional, spiritual, and psychological needs are identified through consultation with consumers, incidents, feedback and changes and strategies are implemented effectively.
* **Requirement 4(3)(e):** The provider ensures there is an available network of services and supports for daily living for timely referral to, and collaboration with, to meet diverse needs of consumers.
* **Requirement 5(3)(a):** The provider ensures the environment is fosters a sense of belonging and becomes a welcoming environment for consumer interaction and function.
* **Requirement 6(3)(c):** The provider ensures staff are aware of their responsibilities to within complaints management processes, including use of an open disclosure process, and the provider demonstrates appropriate responsive action is taken when things go wrong.
* **Requirement 6(3)(d):** The provider ensures all feedback is recorded through the feedback system in line with procedures to ensure areas for improvement are identified, monitored, and actioned.
* **Requirement 7(3)(a):** The provider ensures sufficient staff are deployed to support care and service delivery in line with consumers needs and to meet these Quality Standards.
* **Requirement 7(3)(c) and 7(3)(d):** The provider ensuresstaff are competent in performing their roles including through implementation of effective monitoring, training, and review of staff practice. The provider ensures staff are provided sufficient training where deficits in knowledge and practice has been identified, and the effectiveness of training monitored and reviewed.
* **Requirement 8(3)(a):** The provider ensures activities and actions engage and support consumers in the development, delivery, and evaluation of care and services.
* **Requirement 8(3)(c):** The provider ensures organisational governance systems of feedback and complaints, continuous improvement, workforce governance, information management, and regulatory compliance are effectively implemented and monitored within the service.
* **Requirement 8(3)(d):** The provider ensures there are effective systems in place for managing high impact, high prevalence risks, dignity of risk and incident management and prevention, as well as recognising and responding to abuse and neglect of consumers.
* **Requirement 8(3)(e):** The service ensures there is an effective Clinical Governance Framework in place which encompasses up-to-date and best practice policies relating to open disclosure, antimicrobial stewardship, and the minimisation of restrictive practices. The service ensures staff receive education and training on these topics.

# 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. | Not Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the 6 specific Requirements has been assessed as non-compliant.

The Assessment Team recommended Requirement 1(3)(a) in Standard 1 Consumer dignity and choice not met.

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

The Assessment Team were not satisfied consumers were treated with dignity and respect. Whilst sampled consumers said they were treated with dignity and respect and management and staff spoke respectfully of consumers describing measures to uphold respect, staff interactions with consumers were not always observed to be conducted in a dignified or respectful way. The Assessment Team provided the following evidence relevant to my finding:

* Observed interactions with consumers were not always dignified or respectful, specifically for consumers with changed behaviours and mental health disorders. The Assessment Team reported overhearing sounds of distress coming from a consumer’s room on one occasion when care was being provided to the consumer.
* Strategies for the management of consumers changed behaviours did not demonstrate respect for the consumer or optimise their dignity. The impact of the consumer’s changed behaviours had not been considered for the consumer or for other consumers.

The provider’s response does not refute the findings, however, comprised improvement actions being undertaken including, but not limited to:

* Engagement of an external advisory service to work with management and improve services and experiences for consumers.
* Arranging assessment by a Work Health and Safety Co-ordinator of current processes for consumer safety and dignity, staff safety, and actions to minimise physical restraint.
* Engagement of Dementia Support Australia for review of consumer behaviours, development of management strategies and supports, and approach to develop education for staff.

I acknowledge the provider’s response and actions being undertaken. In coming to my decision, I have placed weight on observed staff interactions with consumers with changed behaviours not considering their dignity and failing to demonstrate respect. The use of restrictive practices for consumers, including physical restraint and seclusion, was not recognised by staff, and did not include risk assessments or monitoring processes for the impact on consumer well-being. One consumer was observed to sound distressed and agitated during care, yet it was not evident that staff considered trialling use of alternate strategies. The service did not demonstrate monitoring processes were effective in identifying the staff practices observed or considering the distress to the consumers displaying the changed behaviours or witnessing them.

For the reasons outlined above, I find the service non-compliant with Requirement 1(3)(a).

**Other Requirements**

Consumers and representatives said the service is considerate of delivering care and services in a way that respects cultural backgrounds and needs. Staff described how the consumer’s cultural needs influence the delivery of care and services, although management advised they did not consider the service had consumers from culturally diverse backgrounds. Care planning documentation captured consumer backgrounds and demonstrated this was considered within provision of care and services. Training on cultural respect was included within mandatory training modules.

Consumers described being supported to make and communicate decisions about care, including the way it is provided. Staff and management explained the importance of understanding consumers to determine how to best support choice and independence, and to develop and maintain relationships. Overall, care plans included sufficient information to inform staff on how to support consumers exercise choice and independence.

Management and staff demonstrated an awareness of risks taken by consumers and outlined the assessment process, including consultation to ensure consumers were informed of the risks, educated on how to minimise harm, and the outcomes documented. Consumers said they felt supported to take risks to live their best life. Dignity of risk assessments were sighted in care planning documentation, identifying the risk and mitigating strategies, although the service could not demonstrate regular review of effectiveness had been undertaken (I have considered this information further in my findings within Standard 2 Requirement 2(3)(e)).

Consumers said they received clear and sufficient information to exercise choice. Management and staff described different way information is provided, considering needs and preferences of consumers with cognitive or sensory impairment. Information was observed to be displayed throughout the service, for example, printed menus were available in the dining areas and consumers received verbal consultation on menu choices to select meals for the following day.

Consumers described consideration and respect of privacy during delivery of care and services. Management and staff explained practical measures taken to maintain consumer privacy and confidentiality. Policies and protocols were in place to inform staff practice. However, the Assessment Team observed strategies for the management of one consumer’s changed behaviours did not consider privacy of the consumer or the impact on nearby consumers, this is considered also within my decision for Requirement 1(3)(a) of this Standard. The provider has provided some further context to the behaviours within their response, and I am satisfied the actions being undertaken to ensure the consumer’s dignity and respect is maintained will also address these needs.

# 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. | Not 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. | Not 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. | Not Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as 4 of the 5 specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements 2(3)(a), 2(3)(b), 2(3)(c) and 2(3)(e) in Standard 2 Ongoing assessment and planning with consumers not met.

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

The Assessment Team were not satisfied assessment and planning accurately captured and reflected risks for consumers, particularly in relation to changed behaviours, and staff could not describe how initial and ongoing assessments inform the delivery of safe and effective care. The Assessment Team provided the following evidence relevant to my finding:

* Care planning documentation for 2 consumers did not capture risks associated with changed behaviours, include management strategies, or evidence informed consent was obtained for use of restrictive practices, resulting in unauthorised use. A third consumer with changed behaviours did not have an assessment of associated risks and strategies within their care and services plan.
* Risks to consumer health associated with the refusal of care had not been identified or used to inform strategies for some consumers.
* Staff and management were unable to demonstrate an applied understanding of assessment processes for falls, pressure injuries, and pain.
* Documentation of assessment and planning in consumer care records was incomplete, contained inaccuracies and did not contain all required assessments. Whilst management were aware of and acknowledged the issues, improvement actions had not been implemented nor captured within the continuous improvement plan.

The provider’s response states they believe there is sufficient additional evidence to support a finding of compliance, supplying evidence and improvement actions being undertaken including:

* Consultation has occurred with family of one consumer regarding updated risk assessments and use of seclusion and physical restraint.
* The training document provided to staff in relation to inconsistencies in care planning documentation, which was available to the assessment team on site.
* Submission of referrals to specialists for consumers identified within the Site Audit report and, where reviews have been undertaken, summary of recommendations.
* Continuous improvement activities being implemented to ensure care plans reflect the needs of all consumers, with ongoing audits every 6 months. Within a month, 6 of the 27 care plans had been reviewed. An audit tool was developed in November 2023.
* Training and education programs for staff. Reminders to staff to remind them to document care, with clinical management to review daily, and monthly audits.
* Engagement of an external consultant clinical advisor.

I acknowledge the provider’s response and actions being undertaken. However, the service was unable to demonstrate assessment and planning had been undertaken to effectively identify risks to consumer health and well-being and used to develop effective management strategies. Deficiencies in documentation failed to inform staff of risks associated with the care of consumers and were not used to inform effective management strategies. Deficiencies in assessment planning were also identified in relation to key areas of consumer care, including skin integrity and wounds, falls, bowel management, and pain.

I do not consider the service demonstrated it had effective systems and processes to ensure assessment and planning was effectively used to identify risks and develop a care plan to inform the delivery of safe and effective care and services. I find the inconsistencies in assessment and planning have impacted the safe and effective delivery of care and services.

For the reasons outlined above, I find the service non-compliant with Requirement (3)(a).

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

The Assessment Team were not satisfied assessment and planning accurately reflected consumer needs, goals, and preferences, including for end-of-life care. The Assessment Team provided the following evidence relevant to my finding:

* Care planning documentation was not reflective of current care for a consumer receiving end-of-life care.
* Care planning did not reflect information on consumer needs and preferences relating to changed behaviours for 3 sampled consumers and had limited information on needs relating to falls management and hygiene needs.

The provider’s response states they believe there is sufficient additional evidence to support a finding of compliance, supplying evidence and improvement actions being undertaken including:

* Documentation for the consumer receiving end-of-life care including family discussions, the palliative care plan and the NSW End of life and palliative care framework and End of life care and decision-making guideline used in the service.
* Continuous improvement activities include improvements to review of care planning documentation relating to end of life care.

I acknowledge the provider’s explanation and documentation relating to the consumer receiving end-of-life care. However, the provider’s response did not address deficiencies identified within the Site Audit report relating to care planning documentation not capturing consumer needs and preferences. This has also not been addressed within the submitted continuous improvement activities for this requirement. Sampled care plan documentation included within the provider’s response demonstrates inclusion of a goal and outcome statement, however, despite being written in the first person, these do not align with observed consumer behaviours, such as resistance to personal care. Whilst I consider the deficiencies mostly arise from poor assessment and planning processes identified in Requirement 2(3)(a) of this Standard, care plans failed to capture consumer needs and preferences. Care planning for consumers did not accurately reflect consumer’s clinical needs and preferences. I find the service’s systems and processes did not ensure care planning documentation accurately reflected consumer needs and preferences for management of changed behaviours, personal care, and emotional supports.

For the reasons outlined above, I find the service non-compliant with Requirement 2(3)(b).

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

The Assessment Team were not satisfied the service demonstrated assessment and planning is based on an ongoing partnership with consumers, representatives, and others involved in consumer care. The Assessment Team provided the following evidence relevant to my finding:

* Staff could not provide examples of how they actively collaborate with consumers, representatives, or other providers of care. Management advised they try to actively involve representatives and consumers, but most consumers do not have engaged representatives.
* For 3 consumers the service did not demonstrate involvement of specialist services to advise on changed behaviours, and for 2 of these consumers identified with use of restrictive practices, the service could not demonstrate consultation with representatives or medical practitioner for informed consent resulting in unauthorised use.
* Care planning and documentation did not demonstrate involvement of consumers, representatives, or Allied health providers within assessment and planning processes.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* Evidence of involvement of Allied health providers in consumer care and/or referrals made.
* Consumer experience survey for July to September 2023 which includes a consumer statement on whether they are supported to make decisions about care and services and reflects most consumers were satisfied.
* Reflection on the challenges of sourcing a Podiatrist and identifies alternate options to raise with consumers and/or representatives.
* A continuous improvement action of partnering, collaborating, and planning with consumers, representatives, and other providers, however, the item does not detail how this will be undertaken.

I acknowledge the provider’s response and actions being undertaken. I have considered the evidence before me carefully before coming to a finding of non-compliance. The Site Audit report identifies deficiencies in partnering with consumers and representatives, which has not been addressed by the provider within responsive documents or continuous improvement activities. Staff could not explain how they partner with consumers and representatives for assessment and planning and management advised the Assessment Team most consumers do not have engaged representatives.

I have placed significant weight on the omission of staff and management to consult with representatives and medical practitioner for 2 consumers resulting in the unauthorised use of restrictive practices. Whilst I acknowledge evidence of reviews by Allied health professionals, evidence provided has not demonstrated how these reviews have been incorporated into assessment, planning, and review of care and services. Based on the provided evidence, I am not satisfied service has demonstrated understanding or application of the process of partnering with consumers, representatives, and other providers to assess and plan delivery of care and services to meet consumer needs and preferences.

For the reasons outlined above, I find the service non-compliant with Requirement 2(3)(c).

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

The Assessment Team were not satisfied systems and processes ensured care and services were reviewed for effectiveness regularly or in response to clinical deterioration or incidents. The Assessment Team provided the following evidence relevant to my finding:

* Inconsistent information was provided on the frequency of care planning review with an initial timeframe of 5 weeks advised however, documentation demonstrated it was every 3 months.
* Care planning documentation did not demonstrate review was undertaken following changes to consumer health or following clinical incidents. Care planning documents for 3 consumers did not demonstrate care and services were reviewed in response to incidents or changes in consumer condition. This included a lack of review demonstrated for effectiveness and strategies for:
  + Following consumers experiencing changed behaviour or incidents arising from changed behaviours.
  + One consumer experiencing falls did not have reassessment of falls risk or prevention strategies, or associated needs of pain, and mobility.
* The service could not demonstrate regular review of effectiveness assessments including Dignity of risk, and social assessments.
* Following incidents of physical or verbal aggression between consumers, the service did not demonstrate assessment of consumer’s psychological well-being.
* Management advised care plans should be updated following incidents or changes.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* Continuous improvement activities being implemented to ensure care plans reflect the needs of all consumers, with ongoing audits every 6 months.
* Evidence of a schedule for routine care plan review and allocation of responsibility to specified staff members. The schedule includes dates for reassessment, undertaking a case conference, and reviewing the care plan.
* Appointment of an external consultant clinical advisor to support care plan review process, and offer support, advice, and education to staff.

I acknowledge the provider’s response and actions being undertaken. The provider has not submitted any evidence demonstrating guidance material is available to staff to inform staff of the frequency of reviews, or what action should be taken to ensure care and services meet changing needs, goals, and preferences of consumers. Whilst I acknowledge the service had a process to ensure these are undertaken and consider the continuous improvement actions demonstrate understanding of the deficiencies in reviewing consumer needs following deterioration and incident management, actions focus on scheduled reviews and do not address how it will ensure reviews are undertaken to evaluate effectiveness of strategies following change of circumstance or following incident.

I acknowledge the actions taken to ensure care and services are reviewed regularly for effectiveness, however, I find the service has not demonstrated systems and processes ensure care and services are reviewed regularly, or particularly when circumstances change or following incidents. Supportive evidence and continuous improvement activities do not clearly address how this is to be managed, leaving consumers with changing needs at risk of outdated management strategies impacting care and safety.

For the reasons outlined above, I find the service non-compliant with Requirement 2(3)(e).

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

Consumers and representatives said communication about the information within the care and services plan was sufficient and were confident they could receive a copy if they wanted. Management explained cased conferences to discuss consumer care were arranged annually, although sometimes representatives declined the to attend. Management explained a summary care plan could be typed up to provide a record to consumers or representatives, if requested. Documentation included record of case conference discussion. I am satisfied Requirement 2(3)(d) is compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as 5 of the 7 specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), and 3(3)(f) in Standard 3 Personal care and clinical care not met.

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

The Assessment Team were not satisfied consumers received best practice and tailored care to optimise health and well-being in relation to use of restrictive practices, wound care, and pain management. The Assessment Team provided the following evidence relevant to my finding:

* Management and clinical and care staff were unable to demonstrate an applied understanding of restrictive practices. Management advised there were no consumers subject to use of restrictive practices, however, documentation and interviews demonstrated chemical restraint was used for one consumer, and another had personal care and behaviour management strategies consistent with principles of physical restraint and seclusion. Policies on restrictive practices were not consistent with legislative guidelines.
* For a consumer with an advanced bilateral pressure injuries, recommendations from a wound specialist were not all being followed and information about the stage of the wound was not available or provided.
* Pain assessments did not accurately identify areas of pain or include strategies. Consumers with changed behaviours and clinical deterioration did not have pain considered as a cause or charting completed.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* All consumers will have pain assessments undertaken by the Physiotherapist with updated care planning.
* Continuous improvement activities include staff education on wound care photography, and dementia specific training on pain assessment and behaviour management.
* Appointment of an external consultant clinical advisor to provide support and education.

I acknowledge the provider’s response and actions being undertaken to address some of the deficiencies, however, remain concerned that these do not specify improvement of staff understanding of best practice guidelines and expectations for wound management, and the importance of following specialist recommendations for wound management.

The service has not demonstrated it has effective systems to ensure delivery of best practice care to meet each consumer’s needs or optimise their wellbeing. Consumer pain was not accurately assessed or understood, and consideration has not been given to it being an underlying cause of changed behaviours. Staff did not recognise actions used as strategies for consumer care and changed behaviours were forms of restrictive practice which had not been authorised.

For the reasons outlined above, I find Requirement 3(3)(a) non-compliant.

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

The Assessment Team were not satisfied the service was able to demonstrate effective management of risks associated with changed behaviours and falls. The Assessment Team provided the following evidence relevant to my finding:

* The service did not demonstrate effective management for high risks for consumers with changed behaviours, with staff routinely using unauthorised restrictive practices. Changed behaviours of consumers were observed to have physical and/or psychological impact on other consumers, however, the service had not developed effective management strategies.
* Risks associated with the refusal of personal care were not assessed or monitored for one consumer.
* Two consumers experiencing falls did not have referral for reassessment of mobility or changed needs due to injury in a timely manner.

The provider has submitted the following evidence and improvement actions being undertaken including:

* A review of documentation for one of the consumers experiencing falls, however, this is limited and does not provide consideration of all aspects of the individual consumer’s care needs.
* A copy of an updated continence plan for a consumer identified as subject to physical restraint.

I acknowledge the provider’s response and actions being undertaken. Whilst I recognise activities detailed against other requirements reflect the intention to undertake a review of all care planning document, I do not consider the response and continuous improvement activities demonstrate understanding of the deficiencies detailed in the Site Audit report against this requirement. Unauthorised and unrecognised use of restrictive practice has been used for 2 consumers, without identification of associated risks and inclusion of monitoring processes for consumer safety and well-being. Behaviours of a consumer have directly impacted on another consumer, however, mitigating strategies had not been used or developed to prevent further occurrence. Consumers experiencing falls did not have a Physiotherapy review in a timely manner to consider risks associated with mobility needs or change of circumstances due to injury. I have also considered evidence in Requirement 3(3)(a) demonstrating monitoring processes failed to detect a consumer’s bilateral pressure injuries in early stages, despite known risks to skin integrity.

The submitted continence care plan for the consumer subject to physical restraint initially appears to support consumer comfort, however, I do not consider this clearly informs consumer safety as included interventions do not recognise potential for pain, and there are no directions for management of consumer distress.

Where consumers regularly refuse hygiene care this creates risks relating to skin integrity, poor oral and dental care, and increase risk of infection. The evidence before me does not demonstrate these risks have been effectively assessed, planned, and managed for all consumers. I find deficiencies within assessment and planning identified within Standard 2 have impacted management of risks associated with the care of each consumer, and the service did not have sufficient systems or processes to identify and ensure effective management of consumer risk, impacting care delivery.

For the reasons outlined above I find the service non-compliant with Requirement 3(3)(b).

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

The Assessment Team were not satisfied care planning documentation and progress notes demonstrated the identification of and response to clinical deterioration. The Assessment Team provided the following evidence relevant to my finding:

* A consumer had increase in changed behaviours over the previous 6 to 12 months before referral was made for specialist review. Timely assessments had not been undertaken, and management did not demonstrate an effective system to ensure changes were identified and managed.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* A continuous improvement activity demonstrating a review of the consumer’s file has been undertaken, listing referrals to specialist services, and recommendations from a specialist dementia service are currently being implemented into care planning.
* Specialised training on dementia care to be coordinated for staff.

I acknowledge the provider’s response and actions being undertaken. I consider evidence provided within the Site Audit report relates to only one consumer, and better aligns with Requirement 3(3)(f) of this Standard, and Standard 2 Requirement 2(3)(e) relating to review of care planning following change of circumstance, both of which have been found non-compliant.

Information relating to other consumers within the report demonstrate monitoring processes are followed for consumers experiencing falls and incidents causing injury. Consumers on a palliative care trajectory have been identified in a timely manner and commenced on end-of-life care. I would strongly encourage the service to ensure staff have sufficient guidance and training to recognise and take timely response to acute and gradual deterioration or change of consumer health, function, capacity, or condition, however, based on the totality of evidence before me, I find the service compliant with Requirement 3(3)(d).

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

The Assessment Team were not satisfied information about the consumer was effectively communicated within the organisation. Care planning and handover documentation did not always provide consistent, contemporary, accurate, or sufficient information about consumers to facilitate delivery of safe and effective care and services. The Assessment Team provided the following evidence relevant to my finding:

* Documentation discrepancies were identified for consumers in relation to dietary requirements and advance care directives.
* Risks were not accurately recorded within care planning documentation, and care plans were disorganised and difficult to follow with conflicting information in varying assessments.
* The service had not communicated risks associated with the use of restrictive practices with substitute decision makers.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* Improvement actions to review and update handover processes with education to staff.
* The care plan review action plan, including discussion with staff of the importance of updating information on all relevant documentation.

I acknowledge the provider’s response and actions being undertaken, however, find service did not demonstrate systems were in place to ensure accurate information is documented and communicated within the organisation. Consumer records were observed to be disorganised, care plans did not capture and clearly identify risks, and handover documents were not consistent with care planning documentation. Whilst the Site Audit report acknowledges staff had worked with consumers for a long time and could demonstrate familiarity with consumer needs and preferences, the provider’s response explains the service had experienced a recent outbreak with reliance on agency staff, dependent upon accurate documentation and handover processes to provide safe and quality consumer care.

For the reasons outlined above I find the service non-compliant with Requirement 3(3)(e).

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

The Assessment Team were not satisfied care planning documentation and progress notes demonstrated timely referrals to providers and organisations. The Assessment Team provided the following evidence relevant to my finding:

* Timely referrals were not made relating to consumer’s changed behaviours, health conditions, and following falls.
* Instances where delayed referrals impacted on consumer condition and health.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* A copy of a referral to a specialist organisation dated 21 November 2023, with response dated 23 November 2023 suggesting referral to organisation more suited to the consumer’s medical history.

I acknowledge the provider’s response and actions being undertaken and consider the service has established referral systems. In coming to my decision, I have also considered evidence submitted by the provider for other requirements. I acknowledge referrals to wound care specialists are timely following identification of wound or injury, and the provider’s response demonstrates established referral processes and involvement of Allied health professionals, providers, and specialists. However, the referral submitted within the provider’s response was lodged 3 weeks after the completion of the Site Audit review, did not consider the consumer’s diagnoses in the selection of provider, and does not demonstrate further actions following non-acceptance.

In making my decision, I have placed emphasis on the management and outcomes for the consumers and find the lack of involvement of external specialists and organisations impacted the safety and well-being of the consumers and others distressed by the changed behaviours.

For the reasons outlined above I find the service non-compliant with Requirement 3(3)(f).

**Requirement 3(3)(g)**

The Assessment Team recommended Requirement 3(3)(g) met, with staff observed using hand hygiene and personal protective equipment, and able to explain precautions to prevent and control infection and minimise antibiotic use. The service monitors NSW government advice and followed recommendations for prevention of outbreak of COVID-19 and had an outbreak management plan.

However, based on the evidence before me, I have come to a different finding. The service did not have an Infection prevention and control (IPC) lead and had not had one on site for over 12 months. This is not in line with directives from the Australian Government Department of Health, which specifies each residential aged care service must have an IPC lead based on site to provide advice and oversight on day-to-day operations.

Management explained how clinical staff work closely with Medical officers to minimise use of antibiotics, however, most clinical staff were not able to describe principles of antimicrobial stewardship. One consumer had been prescribed antibiotics for prevention of infection for nearly 2 years, which is not in line with antimicrobial stewardship principles or best practice prescribing principles.

For the reasons outlined above I find the service non-compliant with Requirement 3(3)(g).

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

I have found Requirement 3(3)(c) compliant. Staff described how they ensure the needs, goals and preferences for consumers nearing end of life are recognised and addressed, and could explain actions to maximise comfort, manage pain, and preserve dignity. Documentation demonstrated consultation with representatives prior to commencement of palliative care. The service has policies and procedures providing guidance on identifying and managing palliative care needs, and inclusion of palliative care specialists and other appropriate specialist services. Within evidence for other requirements, the provider has included a survey measuring representative satisfaction with management of consumer end-of-life care, with positive result.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not 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 is assessed as non-compliant as 2 of the 7 specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements 4(3)(b) and 4(3)(e) in Standard 4 Services and supports for daily living not met.

**Requirement 4(3)(b)**

The Assessment Team were not satisfied consumer’s emotional, spiritual, and psychological well-being was sufficiently supported by the service. The Assessment Team provided the following evidence relevant to my finding:

* Management was not able to describe services and supports in place to manage psychological well-being for consumers with changed behaviours. Following incidents between consumers, including where injury was sustained, consumer psychological well-being had not been assessed.
* The service could not demonstrate tailored strategies were in place to promote the emotional, spiritual, and psychological needs of consumers.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* Planned action to work with consumers to explore the psychological impact of changed behaviours of other consumers and use this to inform action plans.
* A memo to be created for staff to monitor and offer support to consumers affected by changed behaviours of other consumers.
* Consultation with the external consultant clinical advisor.

I acknowledge the provider’s response and actions being undertaken, however, I consider the service did not demonstrate it provide services and supports to promote the emotional and psychological well-being of consumers. Staff were aware of the impact of the changed behaviours of consumers and said they receive complaints regularly, however, had not considered the emotional toll this takes on consumers. Records of participation in activities were not kept, making oversight of consumers at risk of social isolation challenging. The service was identified as intentionally isolating (secluding) a consumer with changed behaviours away from all other consumers without demonstrating consideration of all risks, including monitoring of impact on their emotional well-being.

For the reasons outlined above, I find the service non-compliant in Requirement 4(3)(b).

**Requirement 4(3)(e)**

The Assessment Team were not satisfied the service identified need or placed timely and appropriate referrals to providers for services and supports. The Assessment Team provided the following evidence relevant to my finding:

* Whilst consumers and representatives did not identify issues, staff could not demonstrate understanding of examples relevant to this requirement. Management advised referrals available within the LHD, requiring minimal involvement of outside providers beyond National Disability Insurance Scheme (NDIS).
* The service had not established connections or networks with other organisations or providers relating to this requirement.
* Documentation for consumers with changed behaviours did not demonstrate engagement of specialist providers to connect consumers to meaningful activities.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* A continuous improvement activity to refer consumers with changed behaviours to specialist organisations.

I acknowledge the provider’s response and actions being undertaken. However, the service has not demonstrated how it ensures services and supports are available to ensure consumers have meaning, purpose, and connectedness in their lives. The service is required to have a network of other individuals, organisations, or providers to refer or collaborate with, ensuring the diverse needs of consumers can be met. The service could not demonstrate any actions taken to explore available providers outside NDIS and the Local health district (LHD) service network for clinical care requirements. Whilst consumers did not raise any concerns, they had also not been consulted or assessed on whether there were unidentified needs or wants to optimise their health, well-being, emotional care, or daily living needs.

For the reasons outlined above, I find the service non-compliant in Requirement 4(3)(e).

**Other Requirements**

I consider the other 5 requirements of Standard 4 Services and supports for daily living compliant.

Consumers and representatives were satisfied services and supports for daily living optimised consumer well-being and quality of life. Staff explained the assessment process to identify consumer needs, goals, and preferences and use these to develop programs within the service and adapt them to accommodate changing needs of consumers. Whilst the Assessment Team identified social assessments were not regularly reviewed and updated to capture changing consumer needs, I consider this evidence more relevant to my findings in Standard 2, Requirement 2(3)(e).

Consumers said they were supported to engage with the community, have personal relationships of choices, and do things of interest. Management and staff gave examples of how they supported relationships and encourage consumers do things they enjoy. Consumers were observed interacting with visitors and leaving the service for activities with family or NDIS support workers.

Overall, the service demonstrated information about consumers was shared within the organisation and others responsible for care. Deficiencies in handover processes with other staff have been considered within Standard 3 Requirement 3(3)(e). The service worked closely with NDIS and NDIS support workers, and the service demonstrated effective processes to communicate consumer needs between organisations.

Feedback from consumers and representatives reflected satisfaction with the quality, quantity, and variety of provided meals, with opportunity to give feedback for improvement. Staff demonstrated awareness of consumer preferences, and explained how they catered meals in line with preferences. Dietary needs and preferences were recorded and communicated with kitchen staff. Meals were observed to be of suitable size and quality.

Consumers and representatives advised provided equipment was safe and suitable to individual needs. Staff said they had access to ample equipment to meet consumer needs, and could describe cleaning and maintenance processes, although identified improvements could be made to frequency of cleaning mobility aids and shared equipment. The Site Audit report identifies an incident was attributed to personal mobility equipment that was not suited to the capacity of the consumer, however, I consider this evidence more relevant to findings within Standard 2 Requirement 2(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. | Not 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 is assessed as non-compliant as one of the 3 specific Requirements has been assessed as non-compliant.

The Assessment Team recommended Requirements 5(3)(a) and 5(3)(b) in Standard 5 Organisation’s service environment not met.

**Requirement 5(3)(a)**

The Assessment Team were not satisfied the service’s environment optimised each consumer’s sense of belonging, independence, interaction, and function. The Assessment Team provided the following evidence relevant to my finding:

* Some consumers reported the shared bedroom layout, accommodating multiple consumers in each room, did not optimise their sense of belonging, independence, and function. Consumers and representatives reported the shared rooms were not big enough to comfortably accommodate the number residing within.
* Due to the home layout and proximity of bedrooms, changed behaviours of consumers impacted other consumers causing distress.
* Management was aware of feedback from consumers and representatives, but advised the decision was made to consolidate consumers into the single area due to staffing.
* The service occupancy level has 98 allocated places but only 28 consumers, with management advising they have not been taking new admissions due to the service environment.

The provider’s response states they believe there is sufficient additional evidence to support a finding of compliance, supplying evidence and improvement actions being undertaken including, but not limited to:

* A statement responding to one consumer’s feedback, stating they have always been in a shared room.
* Detailed information about the decision to move consumers, communication strategy, and new room allocations for consumers.
* Activities including planned survey with consumers and/or family regarding the environment with discussion of findings and actions with consumers and representatives in an upcoming consumer meeting.

I acknowledge the provider’s response and actions being undertaken, however, based on the evidence before me, I find Requirement 5(3)(a) is non-compliant. Whilst I acknowledge the decision to consolidate consumers to one unit was based upon perceived necessity, the service has not considered the impact to consumers sense of belonging, independence, interaction, and function. The communication strategy submitted within the response demonstrates consumers were told of changes and the service decided on where consumers would be moved and who they would share rooms with. Management advised the Assessment Team consumer rooms were decided through placing consumers with similar behaviours together. Documentation shows all consumers were impacted by the changes to some degree, either by changing unit, room, or who the room was shared with. Rooms previously occupied by 2 consumers now had 3 or 4 people sharing, giving insight into feedback from consumers and representatives who considered the rooms to feel crowded. The provider’s response indicates one consumer was subsequently moved because of noise arising from changed behaviours of a consumer introduced into the unit. I do not consider the evidence before me demonstrates fostering a sense of belonging for consumers or development of a welcoming environment.

For the reasons outlined above I find the service non-compliant with Requirement 5(3)(a).

**Requirement 5(3)(b)**

The Assessment Team were not satisfied the service environment was safe, clean, well maintained, and comfortable. The Assessment Team provided the following evidence relevant to my finding:

* Maintenance staff said they were not fully up to date with completion of reactive maintenance tasks.
* The cleanliness of the service was not always maintained, despite regular cleaning schedules. A consumer’s changed behaviour impacted on the cleanliness of the service environment, and although staff did clean promptly following this, the service did not demonstrate consideration on the impacts to other consumers and their surrounds.
* Some prevented consumers from moving freely around the environment, as they were not suited for consumers using electric wheelchairs. A cluttered environment was determined a contributing factor to an incident in which a consumer was struck by another consumer in an electric wheelchair, resulting in injury.

The provider’s response states they believe there is sufficient additional evidence to support a finding of compliance, requesting reconsideration of this finding supported by the following evidence:

* A copy of the reactive maintenance tasks requests demonstrating all reactive maintenance tasks had been completed. Two items were opened in 2023, and it is noted one was completed after the Site Audit has been undertaken.
* An environmental cleaning result undertaken in February 2023. The two units open at the time had overall results of 76% and 81% and findings. Following review of the Site Audit report, another environmental audit has been scheduled.

I acknowledge the provider’s response and actions being undertaken. In coming to my finding, I have placed weight on the Assessment Team identifying the maintenance log included items for all health facilities operated by the LHD and acknowledged tasks viewed may not belong to the service. I consider the provider’s evidence of a singular environmental cleaning audit to be old and I would strongly encourage the service to adopt more robust monitoring processes, however, the Site Audit report includes evidence of routine cleaning processes undertaken and staff taking any necessary cleaning following actions of changed behaviour of consumers. I have also placed weight on evidence submitted by the Assessment Team in Requirement 5(3)(c), identifying scheduled maintenance work was completed effectively, with staff able to detail associated processes, effective and cleaning processes related to furniture, fixtures, and fittings. The provider has not responded to the impact of the service environment on the free movement of consumers in electric wheelchairs, however, it is unclear how many consumers this impacts. The environment was observed to be largely clutter free and the Site Audit report referred to responsive actions within the cited incident report including minimisation of clutter following meal services.

Based on the evidence before me, I find Requirement 5(3)(b) is compliant.

**Requirement 5(3)(c)**

Requirement 5(3)(c) is compliant, with consumers reporting satisfaction with cleaning and maintenance of furniture, fittings, and equipment in line with observations. Staff demonstrated understanding of the importance of cleaning and maintaining equipment, furniture, and fittings to ensure consumer safety.

# 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as 2 of the 4 specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirement 6(3)(d) in Standard 6 Feedback and complaints not met.

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

The Assessment Team have recommended Requirement 6(3)(c) as met, with consumer and representatives satisfied with appropriate responses to complaints, and management demonstrating an understanding of open disclosure. However, I have come to a different view than the Assessment Team and find the service non-compliant. The Assessment Team provided the following evidence relevant to my finding:

* Most staff were unable demonstrate awareness of obligations to report complaints, saying they would investigate complaints and escalate to management only if they were unable to resolve the complaint, and were unable to demonstrate application of open disclosure. Management advised that all processes for open disclosure are conducted by management. The service’s open disclosure policy does not clearly indicate the responsibility of staff member or management in the use of open disclosure.
* The omission of complaints from the Feedback register resulted in a lack of evidence to demonstrate use of steps of open disclosure.

Within the provider’s response to Requirement 6(3)(d), they have included the following information and documents relevant to my decision:

* A copy of the Open disclosure policy. The circumstances for use of the Open disclosure process are specified as following a patient safety incident and does not reference use in the context of feedback or complaints.
* A copy of document titles within the staff orientation folder and includes ‘Open Disclosure Fact Sheet’. It is not clear that this fact sheet aligns with the current Open disclosure policy.
* A copy of the Feedback register with limited to no detail outlined in the response to the feedback items documented.

I note the Open disclosure policy is prepared for the LHD for use throughout all facilities, which extends beyond residential aged care facilities. The Complaints management policy and procedure, submitted within provider evidence for Standard 8 Requirement 8(3)(c), includes steps indicative of the expected open disclosure actions but do not identify this as open disclosure, which has the potential to limit staff identification and understanding of open disclosure.

Whilst management advised they were responsible for management of complaints; this is not in line with the Complaints management policy. I have placed weight on staff reporting they investigate and resolve complaints without management awareness despite most staff interviewed not able to explain the steps informing an open disclosure process. Documentation provided does not demonstrate staff training is reflective of the current policy updated in 2023.

For the reasons outlined above I find the service non-compliant with Requirement 6(3)(c).

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

The Assessment Team were not satisfied feedback and complaints were reviewed and used to improve the quality of care and services, finding deficiencies with the service’s system and processes to record and analyse feedback. The Assessment Team provided the following evidence relevant to my finding:

* Feedback recorded within other documentation, such as minutes of consumer meetings, were not reflected in the Feedback and complaint register, resulting in a lack of details including record of responsive actions.
* Staff advised they received multiple complaints relating to changed behaviours of consumers, but they did not record them as complaints as they addressed the issue at the time and would only see a need if there is evident psychological harm to other consumers.
* Management advised the usual practice was to collect all the complaints, record them every few months, and analyse for trends to share with staff. Management acknowledged identified complaints were not included or addressed within continuous improvement activities, although advised ‘nothing could be done’ in relation to complaints about behaviours of one consumer.

The provider’s response states they believe there is sufficient additional evidence to support a finding of compliance, but an outcome within the Continuous improvement plan acknowledges that not all feedback has been entered into the electronic system, and this is to be rectified. The provider has submitted details of the process, expectations of staff, monitoring and reporting processes, and relevant documents including:

* A copy of the Feedback register has been included with limited to no detail outlined in the response to the feedback items documented.
* Activities within the Continuous improvement plan for management to ensure all feedback is updated into the Feedback register, analysis for trending purposes which will be shared with staff, consumers, and representatives, and education for staff. An appointed external consultant clinical advisor will also review and give feedback to management.
* Surveys results on consumer experience and quality of life.

I acknowledge the provider’s response. Whilst the organisation has a system for feedback and complaint management, and there is evidence provided demonstrating linkage to improvement activities, the process is reliant on accurate records. I have placed weight on staff feedback recognising they had received multiple complaints about changed behaviours of consumers but not reported these through available complaint channels, and there was absence of any such complaints within the Feedback register submitted by the provider. It is expected that the organisation will use information from complaints to make improvements to safety and quality systems and regularly review and improve how they manage complaints, and this is reflected in the organisation’s policies and procedures. An absence of recording of complaints impacts analysis and oversight by management, including inability to recognise the impact on consumers and undertake responsive improvement actions.

Within other documents, the provider has included survey results such as Consumer engagement data, Consumer feedback scoring spreadsheet, and Quality of life data and scoring. Whilst they demonstrate some improvement from previous results, there is no analysis, and the continuous improvement plan does not demonstrate these are used to inform improvement actions. Consumers giving answers on the lower end of satisfaction were trended on overall results without exploring what could be done to make improvements. Based on the evidence before me, I do not consider the service has demonstrated use of systems and processes to identify and drive improvement for consumers.

For the reasons outlined above I find the service non-compliant with Requirement 6(3)(d).

**Other Requirements**

Management and staff described processes in place to encourage and support provision of feedback. Staff stated they notify management when consumers raise concern and document complaints in progress notes, however, evidence in Requirement 6(3)(d) demonstrates this has not been sufficient to ensure complaints are always captured within the Feedback register. Consumers and representatives advised they were confident to provide feedback and complaints and aware of available methods. Information on complaint processes and feedback forms were displayed and included options for anonymous submission.

Whilst not all consumers or representatives were aware of available advocates or language services but were comfortable to ask for assistance if required. Management described how the service promotes available services for complaints, advocates, and language through documentation in the consumer handbook and on displayed posters. Consumer meeting minutes recorded a visit from an advocacy service to discuss consumer rights and how to access services.

# 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. | Not 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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not 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 is assessed as non-compliant as 3 of the 5 specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements 7(3)(c) and 7(3)(d) in Standard 7 Human resources not met.

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

The Assessment Team recommended Requirement 7(3)(a) met, reporting consumers, representatives, and staff were satisfied there were sufficient staff to meet consumer needs. Management provided evidence demonstrating they are meeting care minute requirements. Roster allocations demonstrated all shifts were filled, with coverage by casual staff or agency personnel win the event of unexpected absences.

However, based on evidence brought forward within the Site Audit report I have come to a different finding than the Assessment Team. The service occupancy level has 98 allocated places but only 28 consumers, with management advising they have not been taking new admissions, explaining this was due to the service environment. A decision to consolidate all consumers from 2 units into one, resulting in consumers reporting dissatisfaction, was made due to staffing to be able to meet cares of consumers within the larger footprint. Management described challenges with staff retention and recruitment campaigns.

In evidence considered within Standard 2, management advised staff have been too busy to ensure care plans are updated and information consistent, and there was insufficient time to host the education on assessment and planning so a copy of a presentation was given with request for staff to review in their own time.

The provider’s submitted Continuous improvement plan does not include actions to address staffing challenges at the service.

Organisations are expected to consider the different levels of skills and abilities needed to meet consumers’ needs. This includes working out the registered professional and support staff needed, and the supervision and leadership needed. Whilst I have considered staff competency, knowledge, training, and support under Requirements 7(3)(c) and 7(3)(d), workforce planning should consider the differing skills and abilities of staff and I find the evidence before me does not support this occurs.

For these reasons, I find the service non-compliant in Requirement 7(3)(a)

**Requirement 7(3)(c) and Requirement 7(3)(d)**

The Assessment Team were not satisfied the service demonstrated staff have the knowledge to effectively perform their roles and management was unable to demonstrate oversight of mandatory training to ensure the workforce is trained and supported to deliver the outcomes required by the Quality Standards. The Assessment Team provided the following evidence relevant to my finding:

* Management explained the mandatory training process for required staff, however, evidence did not demonstrate this process was being followed, completed by all staff, and training amended to address current needs.
* Staff were unable to demonstrate an understanding of their role and responsibilities in minimising the use of restrictive practice, reporting incidents of physical or verbal aggression between consumers, and use of open disclosure, impacting consumer care and safety.
* The service did not have an Infection prevention and control (IPC) lead and had not had one on site for over 12 months.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* Continuous improvement activities undertaken include providing feedback to staff with interim plan, fact sheets, scheduled education for all staff, updated orientation and staff handbook to include advocacy.
* The external consultant clinical advisor will work with educator and assist with reviewing education content. A questionnaire will be provided to all clinical staff to determine knowledge base.
* A copy of the Mandatory Training Summary Report, however, this was broad across a number of healthcare topics without dates or details to show how it related to this service.

I acknowledge the provider’s response and actions being undertaken and note the education program is still being developed and will be tailored to identified deficiencies in staff knowledge.  I have considered these requirements together due to the impact of staff training, knowledge, and competency on delivery of safe and quality consumer care. This includes the service not having an identified and trained IPC lead. I find the service was unable to demonstrate the workforce had suitable training, support, competencies, and knowledge of best practice in aged care, demonstrated by findings non-compliance within all 8 Standards within this report.

For the reasons outlined above I find the service non-compliant with Requirements 7(3)(c) and 7(3)(d).

**Requirements 7(3)(b) and 7(3)(e)**

The Assessment Team has recommended Requirements 7(3)(b) and 7(3)(e) met.

Most staff interactions with consumers were observed to be respectful, and consumers and representatives said staff were kind, caring, gentle and respectful of each consumer’s identity. Monitoring and management processes occurred to ensure staff interactions were appropriate. I have considered the non-compliance in Standard 1 Requirement 1(3)(a) has occurred due to lack of staff knowledge resulting in deficiencies with assessment, planning, and delivery of best practice care rather than staff behaviour and find the service complaint with Requirement 7(3)(b). I would strongly recommend the service ensures staff receive sufficient information and support to ensure consumers are cared for with kindness and empathy.

Staff and management explained formal and informal processes for assessment, monitoring, and review of staff performance. Documented performance appraisals were completed for staff outlining responsibilities, achievements, and agreed improvements. Investigation and performance management, including provision of education, was undertaken in response to staff errors. Records demonstrated all staff were up to date with completion of scheduled performance reviews.

For these reasons, I find the service compliant with Requirements 7(3)(b) and 7(3)(e).

# 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. | Not Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not 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. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as 4 of the 5 specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) in Standard 8 Organisational governance not met.

**Requirement 8(3)(a)**

The Assessment Team recommended Requirement 8(3)(a) met, reporting consumer and representative satisfaction with the level of ongoing engagement, and available feedback mechanisms. Management described involvement of consumers and representatives in meetings, surveys, audits, and care evaluation processes. Meeting minutes reflected consumer involvement in discussions.

However, based on evidence brought forward within the Site Audit report I have come to a different finding than the Assessment Team. Complaints from consumers and representatives were not consistently identified and recorded, resulting in a lack of analysis and trending. The Assessment Team’s evidence includes minutes where a consumer expressed concern about the consolidation of 2 units into one, which was addressed with ‘reassurance’.

In coming to a finding of non-compliance in Standard 5 Requirement 5(3)(a), I placed considerable weight on the impact of the decision to consolidate consumers to one unit resulting in negative outcomes on consumers’ sense of belonging, independence, and function. The provider submitted a copy of the communication strategy, which does not demonstrate seeking consumer and representative input, instead focusing on informing stakeholders of changes. The service did not demonstration consultation on allocation of rooms, with management advising they assigned rooms based on consumer behaviours. Consumers provided feedback on adverse impacts of these changes including noise, crowding within rooms now shared by up to 4 consumers, and consumers’ changed behaviours, however, these were not recorded by management or used to inform change or improvement activities.

For the reasons outlined above I find the service non-compliant with Requirement 8(3)(a).

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

Whilst the Assessment Team was satisfied the governing body promoted the delivery of quality care and services across the organisation, however, were not satisfied with the oversight of the incident management system, regulatory compliance, and workforce management. The Assessment Team provided the following evidence relevant to my finding:

* Clinical data reported from the service to the governing body was inaccurate. The service reported there was no use of restrictive practices, failing to recognise use of chemical and physical restraint and seclusion without authorisation and informed consent.
* Incident reporting and escalation processes were not effective. Incidents were not being captured and reporting through SIRS had not happened in line with legislation.
* Deficiencies in workforce competency and knowledge had not been identified by management.

The provider’s response states they believe there is sufficient additional evidence to support a finding of compliance, supplying evidence and improvement actions being undertaken including:

* Request for recognition that their position as a State Government provider provides exemption from governing body requirements, which the Assessment Team did not demonstrate awareness of.
* Actions undertaken by NSW Health to develop guidelines for State Government residential aged care facilities to meet legislative requirement, with expert review by Aged and Community Care Provider Association to ensure these guidelines are accurate and remain best practice.
* A Community and aged care services Patient safety officer report dated April 2023. Information relates to combined community and aged care services, making oversight hard.
* Copy of meeting minutes for Community and aged care services clinical quality and patient care committee. This demonstrates attendance by the Director of nursing for the service, and whilst incidents and audits related to the region have been tabled, the only specific item to the service was an update on NDIS audit feedback.
* A document titled ‘RACAC Quarter 4’. This includes the Quality Indicator reports of all 5 NSW Health State Government residential aged care facilities (SGRACFs).
* Continuous improvement actions to address the deficiencies relating to incident management, regulatory compliance, and workforce management.

I acknowledge the provider’s response and actions being undertaken. However, based on evidence brought forward within the Site Audit report I have come to a different finding than the Assessment Team. I find the evidence of deficiencies from the Assessment Team aligns better with my findings elsewhere and have considered it within my decision within Requirements 8(3)(c) and 8(3)(d) of this Standard.

The Site Audit report brought forward evidence of the structure of the governing body, including the hierarchy of responsibility and communication processes. I find the evidence before me demonstrates actions of the governing body to ensure accountability for the delivery of safe, inclusive, and quality care and services.

Where the provider requests recognition for exemptions for governing body requirements, on the basis of being a State or Territory authority, I would like to clarify that these exemptions are limited and specific relating to the membership of governing bodies, establishment and continuation of an advisory board to report to the governing body, and requiring the governing body ensure staff members have appropriate qualifications, skills, or experience to provide the care and services.

For the reasons outlined above I find the service compliant with Requirement 8(3)(b).

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

The Assessment Team were not satisfied the organisation demonstrated effective governance systems in relation to feedback and complaints, continuous improvement, workforce governance, information management, and regulatory compliance. The Assessment Team provided the following evidence relevant to my finding:

* Feedback and complaints: Staff and management acknowledged not all complaints were recorded or registered.
* Continuous improvement: Management advised they do not lodge all actions. Results from clinical indicators, audits, feedback and complaints, or surveys had not been used to inform continuous improvement activities.
* Information management: The service’s information management system for consumer documentation and mandatory training are paper based. Training documents and records were incomplete. Consumer care records contained inconsistencies, errors and incomplete information.
* Regulatory compliance: Staff and management were unaware of their roles and responsibilities in relation to legislated requirements for use of restrictive practices, or incident reporting obligations under SIRS (also considered within Requirement 8(3)(d) of this Standard). The service could not demonstrate employment of an IPC lead in line with Department of Health directives.
* Workforce governance: Deficiencies in staff training and knowledge resulted in unrecognised use of restrictive practices. The service did not have an IPC lead. As reflected in my finding for Standard 7 Requirement 7(3)(a), the service has met challenges in recruitment and retention of staff, and management advised care demands may have had impact on timely care plan reviews and training.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* A copy of the Feedback register and complaints management policies and procedures.
* The Continuous improvement plan advises policies, procedures and guidelines are in place. An IPC lead has been nominated and application for education commencing April 2024 completed, and an external consultant clinical advisor appointed.

I acknowledge the provider’s response and actions being undertaken. However, I find effective governance systems were not applied at service level in relation to feedback and complaints, continuous improvement, information management, regulatory compliance and workforce governance.

I have considered the findings of non-compliance in Standard 6 indicates deficiencies within governance process overseeing feedback and complaints processes. Organisation wide governance systems were not in place for use of continuous improvement activities, captured in a PCI, to assess, monitor, and improve the quality of care and services. Staff did not have access to information to enable the provision of best practice consumer care.

Organisational systems and supports had not been applied at service level to ensure identification and compliance with all relevant legislation and regulatory requirements. Policies and procedures relating to use of restrictive practices did not meet legislative guidelines for aged care, as outlined in *Quality of Care Principles 2014*. Use of restrictive practices had not been recognised, and, therefore, appropriate authorisations, consent, management strategies and monitoring processes, in line with legislative requirements, had not been completed. The service had not complied with legislative requirements for identifying and reporting SIRS incidents. Management was unaware of the service’s obligation to have an IPC lead in line with directives from the Australian Government Department of Health, and the provider’s response does not address why this has occurred nor include related improvement actions.

In relation to workforce governance, I have considered the non-compliance in relation to workforce planning, knowledge, competency, training, and support identified in Standard 7 demonstrates the organisation did not identify service deficiencies in workforce governance systems. The organisational deficiencies in supporting and developing the workforce has had impacted the delivery of safe and quality care and services to consumers, evidenced by findings of non-compliance in all 8 of the Quality Standards.

For the reasons outlined above I find the service non-compliant with Requirement 8(3)(c).

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

The Assessment Team were not satisfied the service had an effective risk management framework, identifying deficiencies within policies and procedures which govern reporting and investigating procedures, resulting in omission of investigation and reporting through SIRS obligations. Clinical audit results and reports to the governing body did not identify all consumer risks, including unauthorised use of restrictive practice. The Assessment Team provided the following evidence relevant to my finding:

* The service’s report to the governing body lacked accurate clinical data on pain management, behaviour management, and use of restrictive practices.
* The Assessment Team identified management of changed behaviours of consumers included chemical restraint, physical restraint, and seclusion, however, staff did not recognise actions as restrictive practices. Identified consumers did not have authorisation including informed consent, or risk assessments for the use of restrictive practice.
* The service did not demonstrate an effective governance system in relation to SIRS incidents. Staff did not demonstrate an understanding of SIRS incidents or reporting obligations, failing to report incidents of physical or verbal altercations between consumers, and near misses. Monitoring processes did not identify failures in reporting of incidents and following SIRS processes.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* Relevant policies and procedures organisational policies including the LHD’s Incident management - London protocol recommendations policy dated February 2023 detailing the investigation process, the Open disclosure policy dated March 2023, the Risk management framework dated 28 October 2022, a Reporting for residential aged care services instruction dated 9 November 2022, and the service specific SIRS policy, dated August 2022
* Continuous improvement activities included submission of SIRS, education, and support for staff regarding SIRS, including use of the decision support tool.

I acknowledge the provider’s response and actions being undertaken. I recognise the availability risk management systems and practices to inform the service, however, find the application of this framework was not effective. Monitoring processes did not identify staff failure to report incidents impacting understanding of the extent of changed behaviours of consumers and placing other consumers and staff at risk.

Management and staff did not demonstrate understanding of restrictive practices, failing to recognise instances of unauthorised use of chemical restraint, physical restraint, and seclusion without consideration of the impact on consumer safety. Documentation from the provider shows SIRS reporting for the unauthorised use of restrictive practice was not made when first brought to management’s attention, but 3 days after receipt of the Site Audit report. I consider this further highlights the service’s lack of understanding of reporting obligations.

The evidence before me does not demonstrate the service was managing risks associated with the care of consumers or effectively using an incident management system to manage and prevent incidents, and staff did not recognise and report incidents of potential abuse and neglect.

For the reasons outlined above I find the service non-compliant with Requirement 8(3)(d).

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

The Assessment Team were not satisfied an effective clinical governance framework was used to achieve positive outcomes of clinical care. Staff practice and knowledge did not demonstrate understanding of principles relating to antimicrobial stewardship, open disclosure, or to minimise the use of restraint, and did not demonstrate how policies and procedures were applied in the delivery of care and services. The Assessment Team provided the following evidence relevant to my finding:

* Clinical governance oversight and monitoring processes did not identify deficiencies in staff knowledge of restrictive practice, resulting in unauthorised use of physical and chemical restraint and seclusion. The service’s policy on restrictive practices, dated 2022, did not correctly identify the different types of restraint. Information within the psychotropic register was not accurate, with management describing this as a clerical error due to combining 2 documents following consolidation of 2 units into one in June 2023.
* Oversight and monitoring processes did not identify deficiencies with staff knowledge of reporting of incidents and complaints and application of open disclosure. Management advised information is escalated to the Director of nursing and General manager, on an ‘ad hoc’ basis.
* The service did not have an IPC lead. Most staff did not demonstrate understanding of antimicrobial stewardship practices. A consumer had been prescribed ongoing antibiotics for nearly 2 years to ‘prevent’ infections.

The provider’s response comprised supporting documents and improvement actions being undertaken including:

* An updated copy of the psychotropic register.
* Staff attendance records for Antimicrobial Stewardship training undertaken 24 November 2023.
* Continuous improvement activities including provision of education to staff through fact sheets, education programs, and assessment of staff knowledge. Planned review of policies and procedures to remove incorrect local guidelines.
* Appointment of an external consultant clinical advisor to provide support and education.

I acknowledge the provider’s response and actions being undertaken. However, I find the provider did not demonstrate the service had systems in place for delivery safe and quality clinical care. Clinical governance and oversight and monitoring processes did not identify deficiencies in staff knowledge and performance, resulting in findings of non-compliance in 4 of the 5 Requirements of Standard 2 Ongoing assessment and planning with consumers, and 5 of the 7 Requirements within Standard 3 Personal care and clinical care.

Staff and management did not demonstrate understanding of restrictive practice, resulting in unauthorised use. Policies, procedures, and training did not inform best practice for staff, with the restrictive practice policy failing to correctly identify the different types of restraint in line with legislation in *Quality of Care Principles 2014*. The psychotropic register submitted within the provider’s response does not contain sufficient information regarding the prescribing of psychotropic medications to demonstrate how these have been considered against legislative guidelines for use of restrictive practice.

In relation to open disclosure, the provider has not demonstrated the service had oversight and monitoring processes. This resulted in failure to identify that staff are not recording complaints and incidents, instead, addressing them without receipt of training of requirement to ensure use of open disclosure. Escalation processes through the service’s management were described as ‘ad hoc’, impacting accurate reporting at an organisational level.

Effective organisation wide systems were not available for preventing, managing, and controlling infections and antimicrobial resistance. Oversight and monitoring processes did not identify deficiencies in staff knowledge, including obligations to minimise use of antibiotics through ensuring they are used appropriately for treatment of infection. Risk assessments for consumers had not identified risks of infection from poor hygiene related to refusal of personal care.

For the reasons outlined above I find the service non-compliant with Requirement 8(3)(e).

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