Wantirna Views Care Community

Performance Report

100 Harold Street
WANTIRNA VIC 3152
Phone number: 03 9847 2500

**Commission ID:** 3158

**Provider name:** DPG Services Pty Ltd

**Site Audit date:** 21 March 2022 to 23 March 2022

**Date of Performance Report:** 28 April 2022

# Performance report prepared by

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

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the Approved Provider’s response to the Site Audit report received 13 April 2022.

# STANDARD 1 COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

Overall, consumers and representatives considered they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they chose. Consumers/representatives said staff value their individual identities, culture and backgrounds. Consumers from culturally diverse backgrounds confirmed their culture was respected.

Care planning documentation included a high degree of detail regarding consumers’ background and lived experience, personal preferences, identity, culture and the most important elements to their life. All care plans aligned with consumer interviews.

Staff were familiar with consumers’ backgrounds and explained ways they support their lifestyle choices and preferences on a day-to-day basis. For example, staff explained how an Italian speaking staff member regularly communicated with two Italian speaking consumers and they delivered most of their care. Days of cultural significance for consumers such as; Australia Day, ANZAC Day, Queen’s Birthday and St Patrick’s Day were widely celebrated in the service.

Staff, all said they have not witnessed any poor treatment of consumers, however if they were to, they would immediately report it to management. Management advised that any such report would be treated seriously, and action and precautions would be taken to prevent a repeated incident.

The Charter of Aged Care Rights and the Elder Rights Advocacy information was included on noticeboards throughout the home. The organisation has policies, procedures and staff training that centre around consumer diversity, respect and cultural awareness. For example:

* Code of Conduct Policy
* Cultural Safety, Diversity and Inclusion Policy
* Dignity and Choice Policy

Consumers/representatives gave examples of how the service supports them to be independent, take risks, exercise choice and make decisions about the care and services provided. Consumers felt supported to maintain connections and relationships. Staff demonstrated an understanding of consumers’ relationships within and outside the service. Staff described various ways they provided choice to consumers on a day-to-day basis.

The service demonstrated consumers are supported to take risks and live the best life they can. The assessment of risk-taking activity occurs in consultation with the consumer, representative and health professionals. Risks are generally identified through the completion of assessments carried out by the appropriate health professional and discussed further with the consumer/representative to provide the opportunity for choice and informed decision-making. Care planning documents identified the areas consumers were supported to take risks. Staff were aware of consumers’ activities that involved risk and the relevant risk management measures were discussed at handovers.

The service uses a variety of methods to provide timely, current and accurate information to consumers and representatives. Consumers and representatives were satisfied they received timely and accurate information to assist them in making choices including; current events inside and outside the service, meal selections, daily activities, and access to health professionals.

All consumers and representatives were satisfied that their privacy was respected, and confidentiality was maintained. Staff had undertaken required training on privacy and confidentiality and could describe the practical ways they respected the personal privacy of consumers. Staff were observed knocking on doors before entering rooms, closing doors to provide care and asking consumers if they wanted assistance when to appeared they might need help.

Management demonstrated how personal information was securely managed online on their portal and how any private information can be disposed of securely in the shredding bin in the administration area. Paper consumer records were kept secure in locked work areas and computers containing confidential consumer information were password protected.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Non-compliance is in relation to Requirement (3)(d). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirements (3)(a), (3)(b), (3)(c) and (3)(e) as not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Most consumers and their representatives were satisfied with the care being received however, there was minimal documented evidence that assessments and care plans were discussed with them.

The service uses a fully integrated electronic care documentation system to complete initial assessments to identify consumers’ needs, goals and preferences when they arrive at the service. A comprehensive agreed care and services plan (ACSP) is completed once the assessment process schedule is completed.

The organisation’s expectation is that the ACSP is reviewed at least every 3-4 months and/or as consumer needs change. A Resident of the Day (ROD) review is undertaken every month. Consumers and representatives are consulted in relation to these reviews. Weekly progress notes are completed by a registered nurse to capture changes and update assessments to reflect current care needs.

The service has policies and procedures available on the intranet to guide staff practice around the assessment and planning of care and services for consumers.

A suite of evidenced-based assessment tools is built into the electronic care documentation system such as nonverbal pain assessments, skin assessments and risk assessments. Paper based heat pack risk assessment and bed pole assessments were available. Staff use handover processes (verbal and interactive handover sheet), progress notes, care plan reviews and alerts on the electronic care system, to communicate care needs, particularly if there had been changes in consumers’ condition or needs.

The service demonstrated the timely referrals of consumers to other providers of care and services such as; medical officers, allied health care specialists such as speech pathologists, podiatrists and dieticians.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

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

The Assessment Team found the service had not demonstrated that assessment and care planning processes, (including consideration of risks) are implemented to inform the delivery of safe and effective care and services.

The service uses a fully integrated electronic care documentation system to complete initial assessments to identify consumers’ needs, goals and preferences when they arrive at the service. A comprehensive agreed care and services plan (ACSP) is completed once the assessment process schedule is completed.

The Assessment Team considered the care documents did not detail the individual’s current needs, goals and preferences because it was generated from prefilled tick boxes resulting in a generic ACSP. Assessment did not appear to take into consideration risk to consumers health and well-being. New admissions did not have their prescribed assessments completed in accordance with the admission schedule. Evidence relevant to the finding included:

* Assessments for two new admissions were not completed in accordance with the schedule. Their skin assessments indicated risk but there were no agreed care needs and preferences recorded to mitigate this risk.
* One consumer with a diagnosis of peripheral neuropathy was prescribed heat packs for pain management but there did not appear to be a risk assessment completed for heat pack use. A risk assessment was completed during the site audit.
* One consumer was assessed as requiring compression stockings by the doctor on 22 November 2021. Their ACSP did not reflect their need for compression garments.
* One consumer had a diagnosis of right index finger cancer however, their skin assessment and ACSP stated they had no history of skin disorders.
* One consumer’s ACSP showed the same paragraph covering toileting, falls risk, falls history and dietary requirements was cut and pasted across the dietary needs care plan, nutrition and hydration care plan, personal hygiene care plan and toileting care plan. The consumer’s dietary needs assessment reflected they were underweight with a Body Mass Index (BMI) of 19.84 however, their agreed goals of care had no interventions noted and stated “Resident has lost 4kg after hospital for falls” with no date noted. The three-monthly update to the ACSP of 19 February 2022 did not pick up or rectify this.
* One consumer’s physical and verbal behaviour ACSP was generated from their respective assessments with only tick boxes utilised and no personalisation noted.
* These observations were raised with management who stated they had updated all assessments. They advised there was a glitch with the system which meant the mobility assessment could not be updated by the physiotherapist, so they made a paper copy.
* Consumers files showed the medical officer and other allied health professionals were involved, where necessary however, there was not always evidence of consumers/representative involvement.
* One consumer was palliating under an external service provider in conjunction with their medical officer. There was no evidence of consultation with the consumer or representative prior to the commencement of the End of Life Palliative Care Plan on 5 March.
* One consumer stated they had not been supplied with a bed pole despite repeatedly asking for one to assist them manoeuvre in bed, as they only had one leg. Management advised they were in the process of assessing the consumer for a bed pole. They presented the completed Bed Pole Risk Assessment on 23 March and advised that it had been implemented.
* Three consumers advised they felt involved in their care plans.
* Clinical staff were able to describe the 3 – 4 monthly care plan review process and the monthly resident of the day (ROD) review. They also described the weekly review by the registered nurse where progress notes are updated. The care plan review schedule was observed in the nurse’s station.
* One care staff member stated they do not look at care plans often. They depend on care alerts and appointment system on electronic management system and handover to inform them of changes to consumer care.

The Approved Provider’s response disputed the finding in the Assessment Team’s report and provided additional evidence and information related to the assessment and planning processes that inform the delivery of safe and effective care. The Approved Provider advised:

* The service consults with residents about their needs and preferences daily, from the time they wake until they go to bed again at night. Staff consult with them about everything they do and their right to manage their own day is respected. These constant daily conversations cannot be captured in progress notes but are a part of the fabric of day to day life at the service.
* The service does not accept the position that care plans are not individualised because tick boxes are selected in the care documentation system. The electronic care documentation system features tick boxes as a quick way to record information from a pick list of common issues or interventions. While the tick list offers a choice of common clinical issues, a box is selected only where the individual consumer assessment indicates it is applicable. There are also free text boxes to record information that is not available in the picklist.
* Recent surveys conducted by the service found:
	+ 100% of representatives responded that the service has met their expectations ‘well’ or ‘very well’.
	+ 92% of representatives surveyed were ‘very’ or ‘extremely’ satisfied with their involvement in the planning of their loved one’s care (the remaining 8% were ‘moderately satisfied’).
	+ 100% of residents surveyed felt they could make decisions about their own care either ‘mostly’ or ‘always’.
* The consumer’s right index finger cancer was noted in the diagnosis section at the top of the skin assessment page of their Agreed Care and Services Plan. It had not been included in the body of the skin assessment. It was added to the body of their skin assessment after the consumer agreed.
* Two consumers had recently entered the service 11 days earlier as respite residents and were still undergoing assessment in line with the respite process. An Interim Care Assessment (ICA) was completed in the first 24 hours of entry and a Summary Care Plan had been generated and was in use. The clinical team were systematically working through the remaining suite of assessments and some of them had not been completed.
* Clinical staff had included the same information for one consumer in several areas of the electronic care plan as they believed it provided a relevant overview. A team member had put the care information about maintaining healthy weight in the wrong place on the assessment however, the management plan was being implemented and the consumer’s weight was stable.
* The consumer that was palliating was implementing their end of life care plan through an external service provider they chose in conjunction with their medical officer. The records of consultation with the consumer and representative would have been kept by the external provider rather than the service.
* A risk assessment was completed by the physiotherapist for the consumer that wished to have a bed pole and a bed pole was installed with a note to staff to monitor for safety. The consumer had only recently entered the service on a respite basis.

Many of the deficits identified by the Assessment Team relate to how the care and services plan is documented in the electronic system as opposed to a lack of assessment and planning processes. Evidence relating to the accuracy and completeness of documentation has been considered under Requirement 2(3)(d) below. The Approved Provider’s response clarified a number of issues raised by the Assessment Team and provided additional evidence that the assessment and planning process was robust, consultation did occur and consumers’ care was not adversely impacted by apparent lapses in assessment timeframes or documentation.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find the service demonstrated it has an assessment and planning process (including consideration of risks) which informed the delivery of safe and effective care and services.

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

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

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

The Assessment Team found the service did not demonstrate that assessment and planning identifies and addresses the consumer’s current needs, goals, and preferences, including advance care planning if the consumer wishes. Documentation did not show that assessment and care planning addressed the consumer’s needs, goals, and preferences. Evidence relevant to the finding includes:

* One consumer undergoing end of life care did not appear to have an up to date Agreed Care and Services Plan (ACSP). For example, constipation was not accurately recorded. Their skin care plan did not reflect the use of booties, an air mattress or a bed cradle, nor did it reflect the swollen legs which was recorded in the notes. The Swallow Screening Tool completed on 13 March 2022 also indicated the consumer could cough on command, swallow water and was alert however, they were unresponsive and on modified food and fluids at the time of the audit. Their Palliative Care Complex Health Care Assessment remained blank for symptom management, assessment of her nutrition hydration, nausea and vomiting, continence management and personal hygiene and family support.
* The Assessment Team observed that the chosen music was not playing in the room of the consumer receiving end of life care at the time they were there.
* Some consumers had hard copy Advanced Care Directives (ACD) on their files. Only one consumer had their Advanced Care Directive uploaded to the electronic system with goals of care and wishes documented as well as an electronic alert to staff about their wishes. This was noted to have been completed on the day of the contact visit on 22 March.
* Two consumers recently admitted for respite care, stated they were not spoken to about advanced care directions since their entry to the service.
* Care staff were not aware one consumer’s end of life status and described her as “going down” and being “not good”. Staff believed the consumer had been fed breakfast on 22 March and said there was no mention of a change to oral intake during handover. They were not aware of the consumer’s assessed need for booties.
* Clinical staff advised that goal of care for a palliating consumer was comfort care, no weight monitoring and food to be offered only if alert. They felt the involvement of external palliative care providers and the medical officer contributed to lack of up to date documentation.
* Management stated that a Plan for Continuous Improvement entry had been made to review the palliative care and advanced care planning process. This would involve reviewing all files to check which resident had an ACD on paper and then uploading it to the electronic system. They would then offer those that do not have one, the opportunity to complete an ACD if they wish. A Palliative Care Champion had been appointed at the service with online training through OPAL and placement yet to be arranged – delayed due to Covid-19 lockdowns.

The Approved Provider’s response did not accept the finding in the Assessment Team’s report and provided additional evidence and information in response to the Assessment Report. The Approved Provider advised:

* The service consults with residents about their needs and preferences daily, from the time they wake until they go to bed again at night. Staff consult with them about everything they do and their right to manage their own day is respected. These constant daily conversations cannot be captured in progress notes but are a part of the fabric of day to day life at the service.
* The specified consumer was receiving appropriate end of life care, in accordance with their wishes and their changing condition and this was reflected in the progress notes.
* Care staff advised that the preferred music was not played continuously but it was played intermittently in accordance with the consumers wishes.
* The consumer and the representative of the consumer were happy with the end of life care provided.
* Care staff not involved in the team directly caring for a consumer receiving end of life care would not necessarily be aware of their current condition.
* The completion of Advanced Care Directives by consumers is voluntary.

I acknowledge the Approved Provider’s response to the Assessment Team report and the additional information and evidence in support of their assessment and planning procedures at the service. I consider various methods may be effective as a means of recording and communicating care instructions, provided all those involved in the care and services have a shared understanding of the protocols for accessing and updating the relevant information. For example, hard copies of Advanced Care Directives on file or use of the progress notes feature in the electronic care system, may be valid methods provided they support an assessment and planning process that identifies and addresses the consumer’s current needs, goals and preferences. I consider that quality care may be delivered in accordance with contemporaneous wishes, ahead of the care documentation being updated, in a rapidly changing situation. While the evidence suggests the service could be better at fostering the consideration and planning for advanced care and end of life needs and preferences, I accept it cannot compel consumers/representatives to confront these arrangements, if they do not wish to. I note the service has already included a project to review the status of advanced care plans for all consumers on their continuous improvement plan and appointed a palliative care champion.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find that assessment and planning identify and address the consumer’s current needs, goals and preferences, including advance care planning and end of life planning, where the consumer wishes.

Based on the evidence (summarised above), I find the Service Compliant with this Requirement.

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

*The organisation demonstrates that assessment and planning:*

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

The Assessment Team found the service did not demonstrate that assessment and planning is based on a partnership with the consumers and representatives and when other organisations or individuals are involved in the care of the consumer their recommendations are not always followed. Evidence relevant to the finding includes:

* Three consumers sampled stated they were involved in their care planning and care plan reviews.
* Clinical staff said they regularly consult consumers/representatives in relation to care plans. There are three-monthly reviews as well as monthly Resident of the Day care plan reviews. Representatives are contacted for the three-monthly reviews. Registered nurses do weekly update notes where they follow up on any outstanding items and discuss these with the consumer and/or their representative.
* One consumer commencing the End of Life Palliative Care Pathway had completed an Advanced Care Directive (ACD) however, it was not uploaded to their electronic care record and a care alert informing staff of their instructions had not been created as per the service’s policy. The hard copy of their ACD was available on their paper file.
* One consumer was reviewed by the medical officer on 21 March with recommendations made for physiotherapy to review them however, this had not yet been undertaken (2 days later) and there was no evidence that a referral had been made to the physiotherapist.
* One consumer’s care documentation did not appear to reflect the recommendations made by the physiotherapist such as: “attend first thing in the morning to avoid agitation and falls, bed NOT in lowest position, 4-wheel frame to be in reach, wear nonslip socks and regular visual checks, bed and chair sensor – attend promptly”.
* Of the files reviewed only one indicated that a Multidisciplinary Case Conference was held in the last 3 months.
* Two consumers undergoing initial assessment as respite admissions stated that they were not consulted or asked about their preferences in relation to care planning and assessment.
* One representative stated that while they had not been updated about their father’s missing dentures (missing on 17 March 2022) overall, they felt well informed about their parents saying, “they (the service) contact me often”.

The Approved Provider’s response disputed the finding in the Assessment Team’s report and provided additional evidence and information related to the assessment and planning processes informing the delivery of safe and effective care. The service advised:

* The service disputes the position that care plans are not individualised because tick boxes are selected in the care documentation system. The electronic care documentation system features tick boxes as a quick way to record information from a pick list of common issues or interventions. While the tick list offers a choice of common clinical issues, a box is selected only where the individual consumer assessment indicates it is applicable. There are also free text boxes to record information that is not available in the picklist.
* Two consumers had recently entered the service 11 days earlier as respite residents and were still undergoing assessment. An Interim Care Assessment (ICA) was completed in the first 24 hours of entry and a Summary Care Plan had been generated and was in use. The clinical team were working through the remaining suite of assessments and some of them had not been fully completed.
* The consumer was referred to the physiotherapist to be seen at the soonest available opportunity. It is not unreasonable to have to wait a few days for an appointment with the physiotherapist.
* A risk assessment was completed by the physiotherapist for a recently admitted consumer that wished to have a bed pole and a bed pole was installed.
* Multidisciplinary case conferences are held regularly if the resident and representatives are available and elect to take part. Evidence of multiple other case conferences was provided.

I accept that comprehensive assessment and planning may be undertaken over a period of time and involve the input of different service providers. The service had completed initial assessments for new admissions and was working towards completing assessments. I find the organisation has demonstrated that assessment and planning is based on an ongoing partnership with the consumer (and others that the consumer wishes to involve) and includes other organisations and individuals that are involved in the provision of care for the consumer. Evidence relating to the accuracy and completeness of documentation has been considered under Requirement 2(3)(d) below.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find that the service works in partnership with consumers/representatives and other providers of care in relation to the assessment and planning of care and services.

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

**Requirement 2(3)(d) Non-compliant**

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

The Assessment Team found the service did not demonstrate that consumers and representatives are engaged in communication regarding the outcomes of assessment and planning with care plans being readily available to the consumer. The service’s care planning processes are electronically based with all staff having access to view the comprehensive care plan. Evidence relevant to the finding includes:

* One consumer’s care plan was not updated for six days to reflect their missing dentures and consequently some care staff were unaware of the situation. Their physical mobility scale dated 5 May 2021 indicated they used a 4-wheel frame however, they were seen mobilising in a wheelchair.
* A consumer’s restrictive practices assessment was not updated following a review and change to their medication chart with no evidence to show that their representative was contacted.
* A consumer was reviewed by the occupational therapist and doctor and prescribed compression stockings. Their care plan did not reflect they were measured and applied by the physiotherapist on 30 November 2021.
* One consumer’s care assessment had the box incorrectly ticked “No” for peripheral neuropathy.
* One consumer’s care plan did not appear to reflect the physiotherapist’s and doctor’s recommendations.
* One consumer’s care plan did not appear to reflect the recommendations of the In Reach nurse relating to their stoma, or the external palliative doctor in relation to diet. The care plan was not up to date in relation to the mode of medication administration being a syringe driver.
* One consumer’s behaviour care plan did not reflect the recommendations of external behaviour consultants advising not to call family when behaviours escalate. Clinical staff were unaware of this instruction or not adhering to it.
* One representative advised they had to repeat conversations with different staff twice in a day. The representative stated that the handover between the shifts is lacking and they have to repeat information.
* Two consumers that recently entered the service had significant gaps in their care documentation after 11 days.
* One consumer, who entered the service on 8 March 2022 did not have a completed Diabetes Screening and Management form until 21 March 2022 and monitoring of their blood glucose levels was commenced on 15 March 2022. No agreed care needs and preferences were listed.
* One consumer’s care documentation indicated “No” to self-medicating while they also had a self-medicating assessment in place which was completed 21 July 2021. Management advised the self-medicating assessment was an old one and they had archived it.
* Care staff were not aware of one consumer’s status of commencing end-of-life care and were not up to date with their changing care requirements.
* One consumer’s care plan and falls risk assessment tool was not updated to have their personal hygiene attended first thing in the morning to reduce falls risk and agitation.
* Management advised the Assessment Team they had identified gaps in their wound care documentation and had logged this on the plan for continuous improvement on 24 February 2022. An audit completed on 17 March 2022 had shown improvement and another audit is due in April for further evaluation.
* Samples of restrictive practices documents were inconsistently completed and not in line with best practice. Management indicated they would review all of them and update them as necessary.
* Advanced Care Directives were not always uploaded onto the care management system, as per expected practice. Management advised they had entered a project on the plan for continuous improvement to review the end of life care and advanced care directives for those consumers who had them in place and upload them to the electronic management system. They would also offer consumers who did not have one, the opportunity to complete one.
* Staff reported various methods that changes in consumers care and services are communicated including; verbally at shift change, through the care alert system and via care plans and progress notes.

The Approved Provider’s response did not accept the finding in the Assessment Team’s report and provided additional evidence and information in response to the Assessment Report. The Approved Provider advised:

* The Assessment Team appear to contradict their finding that, “Overall consumers felt they were involved in the care planning process however, none interviewed stated they had asked to see a care plan”.
* The service asks residents and representatives if they wish to have a copy of their care plan but their experience is that most residents and relatives do not wish to have a copy of the care plan. If a resident or representative (if appropriate) ask to have a copy of their care plan, this can be easily supplied to them from the electronic care planning system. Some have been given copies.
* The representative for the consumer with the missing denture considered the issue was minor and was not concerned. They were happy with the level of regular communication from the service.
* There have been some delays in obtaining signatures from medical officers during COVID-19 related lockdowns.
* Care staff are not responsible for administering topical medications to stoma sites.
* The physiotherapy assessment for the consumer mobilising in a wheelchair stated if the consumer presents as unsteady please ensure a wheelchair.

I note that consumers felt they were involved in the care planning process and that none sampled indicated they had asked to see a care plan. There is no evidence that consumers or representatives have been denied access to their care and services documentation or that the service would not fulfil their obligations to provide access to documentation upon request.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find that the service has demonstrated that outcomes of assessment and planning are effectively communicated to the consumer (or their representative) and that care documentation would be made available to consumers/representatives should they request it. However, I find that the service has not demonstrated that the outcomes of assessment and planning are effectively documented in a care and services plan. The service has a sophisticated electronic care management system however, it is not being utilised diligently, consistently and correctly by all relevant staff and care providers. There are multiple instances identified where care and services documentation was either; not completed, completed incorrectly, entered in the wrong part of the electronic system or not recorded/updated at the appropriate time.

Based on the evidence (summarised above), I find this requirement is Non-compliant.

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

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

The Assessment Team found the service regularly reviews the care and services it provides however, they found the service does not review the efficacy of care and services when circumstances change or when incidents impact on the needs, goals and preferences of the consumer. The Assessment Team found the care planning documentation did not consistently show evidence of review by staff when circumstances change. Clinical monitoring was not consistently identifying when changes in consumer’s condition occurs resulting in a clinical review not being undertaken.

* Clinical staff advised monthly Resident of the Day (ROD) reviews are completed and there are weekly registered nurse updates which involve reading through the previous week’s notes and updating assessments and care plans, following up on any outstanding items and discussing these with the consumer and/or their representative. Clinical staff consult with consumer representatives about care as part of the three-monthly care plan review.
* One consumer was reviewed on 7 January and 22 January 2022 by the medical officer and prescribed various topical treatments however, these changes did not appear to be captured on their personal hygiene, skin or toileting Agreed Care and Services Plan (ACSP).
* One consumer was reviewed on 30 January 2022 by the ‘In Reach’ team for management of their supra pubic catheter. The progress notes indicated that if the stoma site was leaking the doctor must review. This note was not reflected on their Catheter Care Complex Health Care Assessment and as a result not part of their Agreed Care and Services Plan (ACSP) for ongoing monitoring.
* One consumer lost their dentures on 17 March 2022 but this had not triggered a review of their oral and dental health or nutrition and hydration.
* One consumer suffering oedema had been prescribed pressure stockings however these were no longer fitted well and slipped down. It was questioned whether these could act like a tourniquet.
* Care staff stated they rely on their team leader or registered nurse and messaging system for updates on consumers’ care needs.
* Registered staff said that the service communicate changes to consumers and representatives directly during visits or through three-monthly care plan review.
* Care staff said they refer to handover processes both verbal and interactive handover sheet, progress notes, care plan reviews and electronic alerts via the electronic care system, particularly if there had been changes in consumers’ care requirements.
* The Assessment Team noted handover, care alerts, progress notes and care plans being utilised on the electronic management system.

The Approved Provider’s response did not accept the finding in the Assessment Team’s report and provided additional evidence and information in response to the Assessment Report. The Approved Provider advised:

* Clinical staff are responsible for the application of topical medications. The topical treatments were documented on the consumer’s medication chart and applied by the registered nurse. It is not usual practice to update a skin assessment with each new medication prescribed by name.
* It is accepted practice at the service any leakage from the stoma site of a supra pubic catheter, would be reviewed by the doctor. There was no evidence in the progress notes that the stoma site had leaked so there was need to refer this to the doctor.
* The consumer’s denture had only recently gone missing on 17 March and their care and services plan was subsequently updated during the audit. The consumer’s representative was informed and they regarded it as a minor issue and were not concerned that they had not been notified immediately.
* The original compression stockings supplied in early December 2021 were now too large for the consumer’s legs as the oedema was resolving. They were referred to the physiotherapist for remeasure on 21 March 2022 and this was completed on 23 March 2021. The doctor had asked whether a sensation the consumer was feel could have been a tourniquet effect.

I have considered evidence related to the failure to maintain accurate care and services plans under Requirement 2(3)(d) above. Evidence related to the delivery of care has been considered under Standard 3 below.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I am satisfied there is evidence that clinical staff, medical officers, physiotherapists and others regularly review the health status of consumers and the efficacy of the care and services provided. There is also evidence that care and services are adjusted or amended when circumstances change or incidents impact on the needs, goals or preferences of consumers.

While there were instances identified where the care and services for consumer’s had been appropriately adjusted ahead of amending their care documentation, I find the service demonstrated that care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

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

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

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

The Assessment Team also recommended Requirements (3)(a), (3)(b) and (3)(c) as not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Overall, consumers and their representatives felt they got the care they need and they were complimentary of the care provided by the service. However, staff feedback and records indicated that care documentation was not always adequate and maintained correctly. Information about the consumer’s condition, needs and preferences was not always documented and communicated within the organisation, and with others where responsibility for care was shared.

Changes in consumer’s care needs were recognised and consumers and their representatives were satisfied they had access to a doctor or other health professional as they needed it, and this was evidenced in their care documentation and interviews. Progress notes generally reflected changes in a consumer’s condition or health status however the response was not always reflected in their care plans.

Management advised that the service has clinical policies and guidelines to direct the provision of care provided by staff; these are available to staff on the services shared intranet system. Care planning documentation identifies a consumer’s referral to other health care providers is done as needed. Staff described the process for referring consumers to other health professionals. Clinical records mostly reflected timely and appropriate referrals and input/recommendations from medical officers, a range of allied health and other medical professionals including physiotherapist, podiatrists, geriatrician, and wound specialist, however the input was not always documented correctly.

The service has documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. An Outbreak Management Plan supported the service’s preparedness in the event of a COVID-19 outbreak.

Staff demonstrated an understanding of infection control practices which included hand washing before and after contact with consumers, wearing appropriate Personal Protective Equipment (PPE), temperature checks and testing. Also, reporting to the registered nurse if the consumer showed any sign of being unwell. Wiping down shared equipment such as standing machines and hoists between use.

Clinical staff were proud of the way the service managed the recent outbreak in December/January stating they managed to contain the spread of covid-19 to the initial three consumers.

Clinical staff demonstrated an understanding about minimising the use of antibiotics. This included educating consumers and representatives, providing more water and fluids especially during summer, fresh fruits, cranberry juice and effervescent sachets as prescribed. They check vital signs and complete full ward test on urine specimen and reporting to the doctor. Registered staff said that antibiotics are not the first line of treatment for infections unless indicated and prescribed. Infections are documented as part of the clinical indicators reported. The Assessment Team observed the serviced had adequate supplies of personal protective equipment. There were donning and doffing stations, temperature monitoring and screening processes upon entry to the service as well as hand sanitiser and antibacterial wipes.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service did not demonstrate that consumers receive safe and effective personal or clinical care, which is best practice, tailored to their needs and optimises their health and wellbeing.

The Assessment team identified discrepancies between documentation and care and found updates to care planning documents not being undertaken promptly when changes consumer needs occurred. Evidence relevant to the finding included:

* Most consumers and representatives interviewed felt they received the care they needed.
* One recently admitted consumer for respite care was not satisfied with the care provided as they did not get a bed pole initially and their care assessment and documentation was not completed in accordance with expectations.
* One consumer undergoing palliative care did not appear to have an up to date Agreed Care and Services Plan (ACSP). For example, constipation was not accurately recorded. Their skin care plan did not reflect the use of booties, an air mattress or a bed cradle, nor did it reflect the wound care or swollen legs which was recorded in the notes. The Swallow Screening Tool completed 13 March 2022 also indicated the consumer could cough on command, swallow water and was alert however, they were unresponsive and on modified food and fluids. Their Palliative Care Complex Health Care Assessment remained blank for symptom management, nutrition/hydration, nausea and vomiting, continence management, personal hygiene and family support.
* One consumer at high risk of falls was recommended to have their personal hygiene attended first thing in the morning to avoid falls and agitation. This did not appear to be updated in their Falls Risk Assessment Tool or personal hygiene assessment and care plan.
* Three consumers’ skin care plans were incomplete.
* Management advised they had identified gaps in their wound care documentation and had logged this on the plan for continuous improvement on 24 February 2022. All chronic wounds had since been reviewed by a wound care consultant and a further audit completed on 17 March 2022 had shown improvement in processes. Another audit is due in April for further evaluation.
* One consumer’s care documentation identified pain in both legs related to peripheral neuropathy with use of a heat recommended as part of the pain management strategy. There was no risk assessment on record for the use of the heat pack. A heat pack risk assessment was completed on 23 March 2022.
* Management said that clinical indicators were tracked and trended monthly and discussed at meetings. Issues identified triggered education and corrective actions.
* Samples of restrictive practices documents were inconsistently completed and not in line with best practice. Management indicated they would review all of them and update them as necessary.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of consumers receiving safe and effective personal and clinical care. The Approved Provider advised:

* The consumer that requested a bed pole was issued with a bed pole following a risk assessment.
* The admission process for respite care has been reviewed to ensure comprehensive assessment and planning occurs in a timely manner.
* While one care plan was not kept up to date, it did not impact on the level of care and services the consumer received. The consumer expressed their gratitude to the team for the care they received, as did their representative. The care team were aware of the consumer’s needs and these were communicated through handover and other means.
* The care plan of the consumer with peripheral neuropathy did reference this under another heading and they were assessed as having sensation in relation to safe heat pack use.

I note that most consumers and representatives were happy with the care they received at the service and there was no evidence presented of consumer harm related to the care provided. The service has provided additional information in relation to the consumer that expressed disatisfaction and the other issues identified by the Assessment Team. I note there are discrepancies between the documentation and the care provided but I am persuaded this predominately reflects appropriate care advancing ahead of the documentation. I have considered the deficits in documentation identified by the Assessment Team under Requirement 3(e) below.

Having considered the evidence in the Assessment Report and the Approved Provider’s response I find the service has demonstrated that each consumer gets safe and effective personal and clinical care, that is best practice, tailored to their needs an optimises their health and well-being

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

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

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

The Assessment Team found the service was not able to demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer. Evidence relevant to the finding included:

* Consumers subject to restrictive practise did not all have consent signed, or appropriate and timely assessment, review and monitoring identified in their Restrictive Practices Assessment and Consent form.
* One consumer, who entered the service on 8 March 2022 did not have a completed Diabetes Screening and Management form until 21 March 2022 and monitoring of their blood glucose levels was commenced on 15 March 2022. No agreed care needs and preferences were listed.
* One consumer’s self-medication assessment was not completed by the medical officer until almost 2 weeks after admission to the service. The Assessment Team observed medications out on the bedside table of this consumer.
* Care plans for some consumers did not identify their risks.
* One consumer that was identified as underweight had no interventions listed in the agreed goals of care section of his dietary needs care plan.
* Six of six medication charts were not completed with special considerations and other relevant details and were generated from tick boxes with no customisation.
* Clinical staff were able to describe what restrictive practices were and that they use restraint as a last resort as well the requirement to review every 3 months and consent. They stated that the restrictive practices register was maintained by one staff member who was dedicated to that and MO rounds and were aware of the Restrictive Practices Assessment being used on the services electronic management system.
* Clinical staff stated that the secure unit had been allocated extra lifestyle personnel to assist with managing behaviours of consumers suffering from sundown syndrome and this was very helpful.
* Clinical staff were able to describe interventions and strategies to manage consumer behaviours however these details were not reflected in the consumers individual care plans.
* Staff described how handover occurs at the beginning of each shift to identify changes to consumers’ care needs including risks.
* The service maintains a range of policies and procedures on high impact or high prevalence risks associated with care of consumers which are available to staff.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of consumers receiving safe and effective personal and clinical care. The Approved Provider advised:

* Some of the documentation issues raised by the Assessment Team were not correct. The service found the Assessment Team did not understand how the medication records are updated on the electronic and paper systems and does not accept that the use of tick box features is not part of an individualised care record.
* There is a high prevalence, high impact risk register in place at the service. The managers review and report weekly to the regional general manager any resident who is at risk. Two residents are reviewed each week and discussed at the daily Heads of Department meeting. These are discussed by leaders with their teams to ensure that everyone is aware of those residents at risk.
* A revised version of the register designed to identify risks that may not be obvious will be in place from mid-April. This register identifies each resident and covers risks including; diabetes, falls, restrictive practices and wounds to allow identification of residents who have multiple risk factors and higher aggregate risk.
* While the service accepts the initial assessment for one respite consumer had deficiencies, this was not representative of normal practice and processes have been developed to ensure this does not recur.
* The consumer reported as being underweight was receiving a high energy high protein diet in line with their assessed care needs and their weight was within the target range. The team member who completed the assessment had entered the dietary information in the wrong place on the system.
* In relation to the medication being observed on the bedside table, the consumer advised they were interrupted while checking their medication and there have been no further such incidents.

I note the Assessment Team did not report any of the clinical indicators were outside industry benchmarks and overall, consumers and representatives were happy with the care they received at the service. The service has provided additional information in relation to the consumer that expressed disatisfaction and the other issues identified by the Assessment Team. I note there are discrepancies between the documentation and the care provided but I am persuaded this has not had negative impacts on any consumers. I have considered the deficits in documentation identified by the Assessment Team under Requirement 3(e) below.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find the service has demonstrated high impact or high prevalence risks are effectively managed for each consumer.

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

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

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

The Assessment Team found the service was not able to demonstrate consumers who are nearing end of life have their dignity preserved and care is provided in accordance with their needs and preferences. Evidence relevant to the finding included:

* The Assessment Team observed aspects of one consumer’s Advanced Care Directive completed a year ago, did not appear to be being implemented.
* The care documentation for a consumer receiving end of life care showed they were working with an external palliative care provider and their chosen doctor. The consumer commenced the End of Life Palliative Care Pathway on 5 March 2022 however, there was nothing documented about consultation with the consumer and their representative at this time and the paper documentation was not all there. The consumer’s medication chart did not reflect their palliative care status and their Palliative Care and Services Plan was incomplete.
* The Assessment Team noted the progress notes evidenced analgesia being administered to manage episodes of pain for one consumer, though it was not always effective.
* Clinical staff stated that a palliative care champion had been appointed however due to COVID-19 lockdowns they had been unable to attend placement and complete the program.
* Management stated they had logged a plan for continuous improvement to review end of life care and advanced care directives for all consumers. Existing directives would be uploaded to the electronic management system. Consumers that did not have plans in place would be offered the opportunity to complete one.
* The service has various written policies and procedures relating to the delivery of quality end-of-life care.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of consumers receiving safe and effective personal and clinical care. The Approved Provider advised:

* The consumer receiving end of life care was working with a third-party palliative care service and their chosen doctor. Clinical records were being kept by these parties. Pain was being monitored and pain relief was effective according to the progress notes.
* The specified consumer was receiving appropriate end of life care, in accordance with their current wishes and their changing condition and this was reflected in the progress notes.
* The preferred music was not played continuously but it was played intermittently in accordance with the consumer’s wishes.
* The consumer and their representative both advised the service they were happy with the end of life care provided.

I note the service’s additional information about a consumer nearing the end of life receiving care in accordance with their wishes and contemporaneous needs and instructions. I note that voluntary Advanced Care Directives have been completed by some consumers and that the service has identified a plan to review the advanced care and end of life care instructions for all consumers.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find the service has demonstrated the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

Based on the evidence (summarised above), I find that this requirement is Compliant.

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

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

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

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

The Assessment Team found that information about the consumer’s condition, needs and preferences is not always documented and communicated within the organisation and when responsibility for care is shared. Consumer files sampled showed evidence in progress notes of reviews by allied health specialist, palliative care services and In Reach team however, the Assessment Team found some showed the goals, strategies and interventions prescribed were not always communicated and reflected on the consumers individual assessments and care plans. Evidence relevant to the finding included:

* One consumer’s care plan did not appear to reflect the physiotherapist’s and doctor’s recommendations.
* One consumer’s care plan did not appear to reflect the recommendations of the In Reach nurse relating to their stoma, or the external palliative doctor in relation to diet. The care plan was not up to date in relation to the mode of medication administration being a syringe driver.
* One consumer’s behaviour care plan did not reflect the recommendations of external behaviour consultants advising not to call family when behaviours escalate. Clinical staff were unaware of this instruction or not adhering to it.
* One representative advised they had to repeat conversations with different staff twice in a day. The representative stated that the handover between the shifts is lacking and they have to repeat information.
* One consumer, who entered the service on 8 March 2022 did not have a completed Diabetes Screening and Management form until 21 March 2022 and monitoring of their blood glucose levels was commenced on 15 March 2022. No agreed care needs and preferences were listed.
* One consumer’s care documentation indicated “No” to self-medicating while they also had a self-medicating assessment in place which was completed 21 July 2021. Management advised the self-medicating assessment was an old one and they had archived it.
* One consumer’s care plan was not updated for six days to reflect their missing dentures and consequently some care staff were unaware of the situation.
* Care staff were not aware of one consumer’s status of commencing end-of-life care and were not up to date with their changing care requirements.
* One consumer’s care plan and falls risk assessment tool was not updated to have their personal hygiene attended first thing in the morning to reduce falls risk and agitation.
* Management advised the Assessment Team they had identified gaps in their wound care documentation and had logged this on the plan for continuous improvement on 24 February 2022. An audit completed on 17 March 2022 had shown improvement and another audit is due in April for further evaluation.
* Samples of restrictive practices documents were inconsistently completed and not in line with best practice. Management indicated they would review all of them and update them as necessary.
* Advanced Care Directives were not always uploaded onto the care management system, as per expected practice. Management advised they had entered a project on the plan for continuous improvement to review the end of life care and advanced care directives for those consumers who had them in place and upload them to the electronic management system. They would also offer consumers who did not have one, the opportunity to complete one.
* Staff reported various methods that changes in consumers care and services are communicated including; verbally at shift change, through the care alert system and via care plans and progress notes.
* Care staff stated they rely on their team leader or registered nurse and messaging system for updates on consumers’ care needs.
* Clinical staff advised they complete weekly notes to capture changes in care needs.
* The Assessment Team noted handover, care alerts, progress notes and care plans being utilised on the electronic management system.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of care information being documented and communicated within the service. The Approved Provider advised:

* They acknowledged that in some instances there were lapses in care documentation and accepted there was scope for improvement.
* The gaps in documentation did not reflect normal practice and they felt they did not impact the standard of care delivered.
* The Assessment Team did not always view all the relevant documentation in the system and had expressed the view they did not like the electronic care management system in use. For example, the physiotherapy assessment and care and services plan considered incomplete for one consumer, did have the recommendations made by the physiotherapist recorded.
* The clinical and care teams know the residents well. They are aware of their normal day to day needs and do not need to refer to the care plans every day.
* The representative of the consumer with behavioural problems and having difficulty settling, advised the service manager that the team was contacting them exactly the right amount of times.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I note the service has a sophisticated electronic care management system however, it does not appear to be diligently or consistently utilised by all relevant staff. I accept that verbal communication between staff may supplement written information however, sound documentation is fundamental to quality care when the service itself has emphasised the impacts of COVID-19 on continuity of staff and medical personel. I find that there were consistent deficits in documentation identified by the Assessment Team which impacted staff knowledge and meant that information about the consumer’s condition, needs and preferences was not always documented and communicated within the organisation, and with others where responsibility for care is shared.

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

Overall, sampled consumers considered they got the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers felt supported by the service to do the things of interest to them, which included participating in activities as a part of the service’s lifestyle program and/or spend time on independent activities of choice. Consumers said the lifestyle program supports their lifestyle needs and staff assist them to engage in additional independent activities of interest.

Consumers felt their needs, goals and preferences are reflected in the care they receive and the lifestyle they choose to lead. Staff understood what was important to specific consumers and what they liked to do. This aligned with consumer feedback and care planning documents. Consumers said the service regularly seeks feedback in relation to consumer preferences and activities offered via the monthly Resident and Relative Meeting and during activities, and this information is used to develop future activity calendars and events.

Lifestyle staff explained how they complete lifestyle assessments on entry to the service. They build a picture of the consumer’s likes/dislikes, their past working life, interests and history and incorporate that into the lifestyle program as best as possible. The activity calendar is displayed throughout the service and offered to consumers and their representatives.

The service demonstrates services and supports provided promote each consumer’s emotional, spiritual and psychological well-being. Many of the consumers are religious and enjoy practicing their faith, mainly Christianity. The Lifestyle Manager acknowledged the importance of consumers connection to faith and their families, and they try to include as many activities as possible to facilitate this, including the ongoing church service provided by a visiting priest. The Assessment Team observed a religious session in practice with consumers praying, singing and listening to the priest.

Consumers felt their emotional, spiritual and psychological well-being was well supported within and outside of the service. Care planning documentation contained information about their emotional and spiritual or psychological well-being and how staff can support them, and this was in-line with feedback provided by consumers. Staff said they know the consumers well and what is usual for them. If a consumer is feeling unwell or agitated, they can usually tell why and provide necessary emotional support to them.

The service demonstrated they provide services and supports that assist consumers to participate in the community, enjoy social and personal relationships and do the things of interest to them. Consumers spoke about how they are supported to visit family and friends outside the service and have visitors at the service. Following the easing of COVID-19 restrictions bus trips have recommenced, so consumers can access the external environment on a more regular basis. The service still invites in musicians and performers to entertain.

Consumers felt information about their condition, needs and preferences was effectively communicated between staff and those who provide care and services. Staff described the variety of ways in which they share information and are kept informed of the changing condition, needs and preferences of each consumer. Staff outlined how progress notes are made for each consumer and changes to care plans are made as things change. Shift handover notes confirmed staff communicate relevant information related to services and supports.

The service demonstrates timely and appropriate referrals are made to individuals, other organisations and providers of other care and services. There are organisational procedures guiding the referral to external services and a variety of brochures and resources were available to direct consumers to external organisations. For example, the service assists consumers arrange visits to their general practitioner. If consumers cannot get transport with family or friends, the service will arrange a staff member to escort the consumer there.

The service demonstrated the meals provided are varied and of suitable quality and quantity. Most consumers expressed satisfaction with the variety, quality and quantity of food currently being provided to consumers at the service. Most consumers stated they had no particular issue with the food and were happy with the quality and quantity of the food provided. Indicative consumer comments were “extremely good meals” and that the food is “pretty good on the whole” and the “choices are always good”.

Consumers’ dietary information in the kitchen was current and staff were observing food safety and workplace safety protocols. Catering staff could explain specific dietary needs and preferences of consumers. Staff are involved in ongoing meetings to ensure all consumer needs are met during mealtime. The head chef meets with management to review meals regularly. The kitchen was observed to be clean and tidy and the current Food Business License was displayed.

Equipment provided by the service was safe, suitable, clean and well maintained. A wide range of mobility aids and lifestyle activity products were available to support consumers in there daily living and activities. Consumers said the equipment was sound, clean and well maintained. Maintenance staff reported equipment is cleaned and maintained regularly and they clean and sanitise equipment as necessary following use. Staff could describe the process to document and report when equipment is faulty. Maintenance documentation showed that scheduled preventative maintenance has been completed.

The service conducts regular inspections on all equipment to ensure operational integrity and safety.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

Overall consumers felt they belong in the service and felt safe and comfortable in the service environment.

The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence and function. The service environment is visually welcoming, with dementia enabling principles of design, safety features and freedom of movement both indoors and outdoors. There is signage to direct consumers and visitors to the various areas of the home.

All consumers stated the service is an enjoyable place to live and they felt at home. Consumers’ rooms were personalised with photographs, mementos and artwork.

The service is large, with many medium-sized communal indoor areas where consumers congregate to participate in activities, socialise or sit quietly. There is a centralised auditorium at the front of the building and a main dining hall where most consumers come to eat. There are several courtyards and gardens with shaded areas and outdoor furniture. Consumers were observed enjoying morning tea, spending time together, participating in activities in the auditorium and moving freely both indoors and outdoors. External pathways were level and free from trip hazards. Whilst there are security measures in place, consumers can freely access internal areas and the courtyard. Consumers were invited to attend daily walks outside of the service, if they wished.

All areas of the service appeared to be safe, clean, well maintained, and at a comfortable temperature. Furniture, fittings and equipment appeared to be safe, clean and well-maintained.

Consumers expressed confidence the furniture, fittings and equipment were safe, clean, well maintained and suitable for them. They said they felt safe when staff used mobility or transfer equipment on them. Consumers who required mobility aids were observed using them freely and could access them when needed. Lifting equipment is maintained and cleaned between use.

The service has a fire detection and alarm system and a call bell system that was observed to be operating effectively.

Maintenance documentation evidenced regular maintenance of the service environment. The maintenance program included planned, periodic and ad hoc maintenance in response to maintenance requests. Maintenance staff undertake a “tick and tag” system where all new equipment is assessed and once approved tagged with a sticker if it is safe to use. The service also conducts a tri-annual living environment audit.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

All consumers/representatives felt encouraged, safe and supported to provide feedback and make complaints. Consumers that had reported issues or complaints were satisfied with how they were resolved.

Consumers/representatives said on entry to the service they received information about the complaints and feedback processes available. They are reminded of these processes at consumer meetings and during formal and informal discussions with staff and management.

Whilst most consumers/representatives said they would make a complaint or provide feedback by speaking directly with staff or management, they were aware of the feedback forms and consumer meetings available to them.

The service was able to demonstrate consumers/representatives were made aware of, and have access to, advocates, language services and other methods for raising and resolving complaints. Most consumers/representatives were able to explain the internal and external feedback and complaints mechanisms available to them, including advocacy support and language services. Consumers said when raising an issue, management generally acknowledges their complaint, promptly addresses the issue and resolves it to the consumers’/representatives’ satisfaction. They felt confident that their feedback was considered by the service and suggestions were implemented as far as reasonably practicable. Consumers/representatives said the most significant changes recently made at the service relate to special food needs, timeliness of care and consistency of service across consumers.

Management explained the consumer admission pack, notice boards and brochures outline the internal and external complaints avenues available to consumers. Feedback forms and lodgement boxes were available in the communal areas and are also regularly sent to representatives. Consumers are also given the opportunity to make a complaint or provide feedback at the monthly consumer meetings and during informal and formal discussions with staff and management.

The service demonstrated that appropriate and timely action is taken in response to complaints, and an open disclosure process is applied when things go wrong. Consumers/representatives advised that management promptly addresses and resolves their concerns and provide an apology when an incident has occurred, or things go wrong. The service was able to demonstrate that feedback and complaints are trended, analysed and used to improve the quality of care and services. Improvement actions taken in response to feedback and complaints are subsequently evaluated in consultation with consumers/representatives.

The complaints register showed that complaints, feedback, suggestions and incidents have been documented, along with planned improvement actions, timeframes and evaluation notes. Consumer and staff meeting minutes showed that complaints and feedback are discussed at each meeting, and actions taken by the service are evaluated with consumer involvement.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Assessment Team recommended Requirement (3)(a) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Some consumers, representatives, and staff reported there have been issues with the shortage of staff and sometimes the quality of care and services has been impacted by these shortages. The service demonstrated the workforce interacts with consumers in a kind and caring manner, and that staff are respectful of each consumer’s identity, culture and diversity.

Consumers said staff engage with them in a respectful, kind and caring manner according to their individual identity and needs and are gentle when providing care. Staff were observed referring to consumers by their preferred name and engaging in friendly and familiar conversations.

The service demonstrated that members of the workforce have the qualifications and knowledge they need to effectively perform their roles. Consumers said staff have the knowledge to perform their duties effectively, and they are confident that staff are trained appropriately and are skilled to meet their care needs. All consumers said staff were capable and they did not suggest any areas where additional training was required.

The service determines whether staff are competent and capable in their role by having position descriptions, minimum qualifications, mandatory training and competencies. Registration requirements must be met for specific roles and all staff have current criminal history checks completed.

The service was able to demonstrate how the outcomes required by the quality standards are delivered through a workforce that is adequately recruited, trained, equipped and supported. Training is monitored monthly and if any training is missed it is notified to management. General managers receive a monthly report and staff cannot work without having completed mandatory training. Staff were able to describe the training, support, professional development and supervision they received during orientation and on an ongoing basis.

The service was able to demonstrate that the performance of the workforce is regularly assessed, monitored and reviewed. Performance reviews are conducted every year and followed up on an as required basis including consideration of consumer/representative feedback.

There are robust orientation and onboarding processes in place for new staff. Buddy shifts with experienced staff are used during the probationary period. Staff performance is monitored through observations of core competencies, analysis of internal audits and clinical data, and consumer/representative and staff feedback.

The service has documented policies and procedures that guide the management of the workforce, the selection and recruitment of new staff, orientation and probationary processes and monitoring of staff performance.

## Assessment of Standard 7 Requirements

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

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

Some consumers/representatives and staff reported there have been issues with shortage of staff due to COVID-19 infections in the service and sometimes the quality of care and services has been impacted by staff shortages.

* One consumer said there are staff shortages sometimes, but this has not impacted the service and they have not experienced call bell delays.
* One consumer said there are not enough staff sometimes, but the call bell response is usually prompt and rarely above 10 minutes and they do not have to wait for help with mobility when needed.
* One consumer and representative said there have been staff shortages when there were high numbers of COVID-19 infections, but this is improving now and that there has been no impact on services and the call bell response is good.
* One consumer said there are limited staff which has impacted on some of the care by being sometimes rushed.
* One consumer said that staff shortages mean they “are rushed off their feet sometimes” and they are left waiting for longer periods with no one available to see them, but it does not worry them.
* One consumer said that sometimes care staff do not acknowledge their requests because they are busy and that they sometimes do not spend as much time with them as they would like.
* Staff confirmed there have been issues with staff shortages which have sometimes impacted on consumer care. Measures are used to fill vacant shifts where possible. They said during busy times, they work as a team to complete tasks and meet consumers’ needs and agency staff are used.
* Management advised recruitment is underway to address the vacant shifts and unplanned leave. Shifts are extended for rostered staff wherever possible and the same agency staff are booked to ensure continuity of care. Backfill from other areas occurs to assist.
* Call bell response times are recorded daily and reviewed monthly. 90% occur within 10 Minutes and are occasionally longer due to not being switched off or due to someone standing on a sensor mat.
* There were 29 vacant care staff shifts in a recent past fortnight.
* Staff allocation records indicated that all shifts have registered nurses and care personnel available.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of care information being documented and communicated within the service. The Approved Provider advised:

* The COVID -19 pandemic has been challenging across the Aged Care sector and the service has not been immune to those challenges. The service does not accept the view that residents do not receive excellent care.
* Team members work together to ensure that resident care needs are met in a timely manner. An extra “hybrid” shift to cover both morning and afternoon shift had been added to the Master Roster to reflect the level of sick leave related to COVID-19 infections in an attempt to cover shifts before team called in sick.
* Of the six consumer comments in the Assessment Report, three indicated that there was minor disruption to their care and services during the pandemic, however this does not represent “most” of the residents.
* Larger surveys conducted by the service between September 2021 and March 2022 found the expectations of all respondent residents and representatives were being met and residents were getting the help they needed.
* The roster reviewed by the assessors was the master roster, which is written to reflect full occupancy of the beds. In the time period reviewed, there were 6 unoccupied beds which needs to be taken into account when considering staffing levels. During periods of lower occupancy, there are times when shifts do not need to be filled and this is managed taking into account resident acuity. These vacant shifts would align to the occupancy reduction.

While some consumers thought the service was, or had been, understaffed, most comments also indicated they were not concerned or largely happy with their care. Resident survey results across a larger sample corroborate high satisfaction. The overall reported call bell response times are reasonable. I note the service has emphasised the impacts of COVID-19 on continuity of staff across the sector and I consider their stated plans to manage staffing and care delivery reasonable under the circumstances. Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find 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.

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

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

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

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

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

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

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

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

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

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Assessment Team also recommended Requirements (3)(c), (3)(d) and (3)(e) as not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Overall sampled consumers considered that the service is well run and that they can partner in improving the delivery of care and services. Consumers/representatives could provide examples of how the service supports their involvement in the development, delivery and evaluation of care and services. For example, they all said they contribute to their care plans and committees.

Management and staff were able to describe the ways in which consumers are encouraged to be engaged and involved in decisions about changes to the service, and the development, delivery and evaluation of care and services they receive. Feedback is continually sought from consumers/representatives about the service environment, delivery of clinical and personal care, lifestyle activities, food and meal service, staffing and their overall satisfaction. A variety of mechanisms are used to encourage input including; monthly consumer/representative meetings, feedback forms and commentary and surveys. Management was able to provide examples of recent changes to the service which involved the input of consumers/representatives.

The service was able to demonstrate that the governing body is accountable for the delivery of care and services, and promotes a culture of safe, inclusive and quality driven culture. The service is governed by a Board who meet monthly to monitor the performance of the service and to ensure they are accountable for the delivery of safe, inclusive and quality care and services. The Board sets clear expectations for the service, and regularly reviews risks from a service and consumer perspective. Risk and clinical governance meetings report to the Board and communicate back to the service. The service uses an information technology system incorporating the Enterprise Risk Management Framework to monitor and oversee the following operations and associated risks:

* + Strategy
	+ Governance
	+ Finance
	+ Human Resources
	+ Occupational health and safety
	+ Infection control
	+ Consumer care
	+ Services and supports
	+ Legal and regulatory

The governing body receives various monthly reports, from the service relating to internal audits, consumer/representative and staff feedback and complaints, continuous improvement, reported hazards and risks, and clinical and incident data analysis. The governing body use this information to; ensure the service’s compliance with the quality standards, monitor care and service delivery and initiate improvements.

The service demonstrated there were effective governance systems in place to guide continuous improvement, financial governance, regulatory and legislative compliance, and feedback and complaints, and workforce governance. However, the Assessment Team found the governance arrangements around information management were not effective as they identified a number of deficits in clinical care documentation. They found that care planning documentation was often not current or accurate, resulting in staff not meeting the care needs of consumers.

The service could show there were risk management systems and practices in place, however, the Assessment Team did not consider these systems were being effective. The Assessment Team found that the service was not adequately identifying and managing consumer risks, with individualised risk mitigation strategies not being documented. Risks were noted particularly with regard to medication management, wound care and weight loss. Management provided the service’s documented risk management framework, including policies describing how:

* + High impact or high prevalence risks associated with the care of consumers is managed.
	+ Abuse and neglect of consumers is identified and responded to.
	+ Consumers are supported to live the best life they can.
	+ Incidents are managed and prevented.

Staff confirmed they had received education on these topics and were able to provide examples of relevance to their day to day work.

The service has a clinical governance framework that includes policies pertaining to; antimicrobial stewardship, restrictive practices and open disclosure. However, the Assessment Team found that clinical governance over care planning, management of restrictive practices, pain, and skin integrity to be inadequate. The service provided:

* + a documented clinical governance framework
	+ a policy relating to antimicrobial stewardship
	+ a policy relating to minimising the use of restraint
	+ an open disclosure policy.

Staff had been educated about the policies and were able to provide examples of their relevance to their work. Staff advised they had received mandatory training and education on infection prevention control practices, complex aged care procedures and minimising the use of restrictive practices.

Staff were able to describe strategies to minimise the risk of infections, such as ensuring strict adherence to hand hygiene, appropriate donning and doffing of PPE, and timely identification of infection-related symptoms.

Clinical staff demonstrated a shared understanding of antimicrobial stewardship and explained the need to discourage unnecessary use of antibiotics, to obtain pathology results prior to medicating and to utilise preventative strategies such as hand hygiene and encouraging fluid intake.

Staff interviewed demonstrated a shared understanding of the requirements around using restrictive practices, including the need to obtain consent, trialling alternative interventions prior to using any form of restraint and monitoring restraint when in use.

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The service demonstrated there were effective governance systems in place to guide continuous improvement, financial governance, regulatory and legislative compliance, and feedback and complaints, and workforce governance. However, the Assessment Team found the governance arrangements around information management were not effective as they identified a number of deficits in clinical care documentation. They found that care planning documentation was often not current or accurate, resulting in staff not meeting the care needs of consumers.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of the risk management systems and practices. The Approved Provider advised:

* The Assessment Report included a number of contradictions in evidence which are not consistent with a finding of Not Met.
* While there are some areas for improvement identified, given the significant challenges related to the COVID environment, a finding of Not Met is not justified in this organisational governance requirement.
* The organisation has effective governance systems for information management. They are concerned that the Assessors have made determinations around a lack of governance rather than identifying the limited areas where there is scope for some improvement.

I have found that there were deficits in relation to the adequacy of documentation that resulted in non-compliance in other Requirements however, I do not find that the examples of failure to create or maintain correct care records are attributable to a lack of effective organisation wide governance systems relating to information management. The deficits in care documentation appear more characteristic of lapses in staff practices, checking and supervision.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find the service has demonstrated there are effective organisation wide governance systems across all the required areas.

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

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

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

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

The Assessment Team found the service demonstrated they had risk management systems and practices in place, however these systems were assessed as not being effective. The Assessment Team found that the service was not adequately identifying and managing consumer risks, with individualised risk mitigation strategies not being documented. The Assessment Team found the service was not adequately managing the risks associated with medication management, wound care and weight loss. There were instances where risks had not been identified and where identified risks did not have individualised risk mitigation strategies in place to reduce the risks to the consumers.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of the risk management systems and practices. The Approved Provider advised:

* The Assessment Report included a number of contradictions in evidence which are not consistent with a finding of Not Met.
* While there are some areas for improvement identified, given the significant challenges related to the COVID environment, a finding of Not Met is not justified in this organisational governance requirement.
* The organisation has solid risk management systems as the backbone to its governance system. They are concerned that the Assessors have made determinations around a lack of governance rather than identifying the limited areas where there is scope for some improvement.

I have found that there were deficits in relation to the adequacy of documentation that resulted in non-compliance in other Requirements however, I do not find that the examples of failure to create or maintain correct care records are attributable to the lack of adequate risk management systems and practices. The deficits in care documentation appear more characteristic of lapses in staff practices, checking and supervision.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find the service has demonstrated there are effective risk management systems and practices across the required areas.

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

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

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

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

The Assessment Team identified a number of deficits in relation to Standards 2 and 3 which they have also attributed to inadequate clinical governance arrangements.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of the governance arrangements. The Approved Provider advised:

* The Assessment Report included a number of contradictions in evidence which are not consistent with a finding of Not Met.
* While there are some areas for improvement identified, given the significant challenges related to the COVID environment, a finding of Not Met is not justified in this organisational governance requirement.
* The organisation has solid clinical systems as the backbone to its governance system. They are concerned that the Assessors have made determinations around a lack of governance rather than identifying the limited areas where there is scope for some improvement.

I have found that there were deficits in relation to the adequacy of documentation that resulted in non-compliance in other Requirements however, I do not find that the cases of failure to create or maintain correct care records is attributable to the lack of an adequate clinical governance framework. The deficits in care documentation appear more characteristic of lapses in staff practices, checking and supervision.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I find the service has demonstrated there is a clinical governance framework which includes; antimicrobial stewardship, minimising the use of restraint, and open disclosure.

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

# Areas for improvement

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

* Requirement 2(3)(d) - The service must ensure the outcomes of assessment and planning are effectively documented in a care and services plan that is readily available to the consumer, and where care and services are provided.
* Requirement 3(3)(e) - The service must ensure that 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.