Performance

Report

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| Name: | Woodlands Aged Care and NDIS Services |
| Commission ID: | 5264 |
| Address: | 34 Free Street, NEWMARKET, Queensland, 4051 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 September 2024 to 18 September 2024 |
| Performance report date: | 18 October 2024 |
| Service included in this assessment: | Provider: 914 Mellreach Pty Ltd  Service: 3621 Woodlands Aged Care and NDIS Services |

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

**This performance report**

This performance report for Woodlands Aged Care and NDIS Services (**the service**) has been prepared by Bruce Bassett, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 5 October 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

* The service must ensure that consumers are treated with dignity and respect and their identity, culture and diversity valued, with particular reference to the ability of consumers to exit the service and receive personal cares as per their preferences.
* The service must ensure each consumer receives safe and effective clinical and personal care, with particular reference to the use of restrictive practices.
* The service must ensure the service environment is clean, safe, well maintained and enables consumers to move freely within the service, both indoors and outdoors.
* The service must ensure the governing body is accountable for the delivery of safe, inclusive and quality care and services.
* The governing body must ensure the service has effective organisation wide systems with respect to information management, continuous improvement, workforce governance, regulatory compliance, feedback and complaints.
* The service must ensure it has an effective incident management system that manages high impact or high prevalence risks associated with the care of consumers and identifies and responds to abuse and neglect of consumers.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Not Compliant |

Findings

The Assessment Team report noted consumers said they did not feel respected, or their dignity valued when they are not allowed to leave the service. For example, a named consumer who entered the service in September 2024 said he is not allowed to leave the service and is prevented when he attempts to leave. He said he requested the keypad code but was told he was not allowed to have it, which made him feel like he had done something wrong.

Another named consumer said he feels staff do not respect him as he is not allowed to know the code to exit the service. He leaves the service to buy cigarettes but has been told the code will not be provided to him as he will tell other consumers.

Staff said the consumer may leave the service when permission is granted but is not allowed to know the keypad code. A review of the consumer’s care documentation does not evidence he has been identified as subject to an environmental restraint or informed consent for restraint obtained.

In response to the Assessment Team report, the service advised in the past, consumers have been provided with the keypad code and then shared it with other consumers, one of whom was under parole conditions. The service noted other consumers were on a treatment authority through the Older Persons Mental Heath Service (OPMH), or on drug and alcohol treatment plans. The service also noted in the past issues such as domestic violence orders and upcoming court orders have also been problematic. The service advised responsibility for consumer and community safety was a priority responsibility.

The service advised that following the Assessment Team report an additional staff member has been rostered on weekends to assist consumers to have free access and egress to the service, the door code had been printed and pasted to the side of the keypad at the front door and by the service lift. The service is working with consumers to show them how to use the keypad and the governing Board has approved the removal of the keypad at the front door to be replaced with swipe card access. Swipe cards will be issued to consumers.

The Assessment Team observed a named consumer telling management he would like a shower and has not had one in a week. A review of his progress notes identified he refused a shower on 12 September 2024 and did not record any follow up by care staff. Staff said they were sometimes unable to provide consumers with appropriate personal cares due to their changing behaviours.

In response to the Assessment Team report, the service advised the consumer often refused showers and follow up offers were documented showing ongoing refusal. The consumer often only accepted face and hand washing and had signed a dignity of risk (DOR) form in relation to their level of hygiene cares.

Another named consumer with a diagnosis of dementia was observed by the Assessment Team to be unwashed with long dirty hair, long toenails and significantly dry skin. Staff said the consumer refuses personal care and becomes physically and verbally aggressive when staff attempt to provide care. Staff said, sometimes if they try at a later time, he will comply. The Assessment Team observed staff approach the consumer to ask if he would like a haircut the next day. The consumer repeatedly said, “I cannot hear you”, but the staff member did not utilise any other strategies to communicate other than speaking louder.

In response to the Assessment Team report, the service advised there is one permanent staff member the consumer will allow to assist him with hygiene cares. The consumer’s representative advised the consumer has always been reluctant with personal hygiene and a DOR had been signed in relation to refusal of cares. The response also said the consumer refuses to use their new hearing aids.

The Assessment Team observed staff not treating consumers in a dignified and respectful manner on a number of occasions. For example, the Assessment Team observed 2 staff sitting on the armrests of a consumer’s chair, they were on their mobile phones, talking to each other and laughing over something. Neither staff member was observed engaging with the consumer. Staff were also observed standing over 3 consumers while assisting them with their meal. Consumers were not brought to the dining area but assisted in the common room. The Assessment Team observed no interaction between the staff members and the consumer while being assisted except for staff saying ‘meat’ while bringing the spoon to the consumer’s mouth. Repeatedly, staff were observed offering another spoonful to consumers prior to allowing consumers to swallow the first spoonful.

In response to the Assessment Team report, the service acknowledged the incident with the consumers sitting on the armrests of a consumer’s chair and said they had received re-education regarding this, while noting the staff were on service provided devices for documenting delivery of cares and not their mobile phones. The service also advised a training session for staff had been booked with Dementia Services Australia (DSA) regarding communication and relationships. The service noted staff were also educated regarding the importance of interacting with consumers in a meaningful way while assisting consumers with meals.

I acknowledge the actions undertaken by the service to address the deficiencies identified during the assessment contact. I also note the difficulties involved in providing cares for specific consumers as highlighted in the service response. However, I am persuaded the service could not demonstrate consumers are treated with dignity and respect with regards to the provision of personal choice in deciding when personal care is completed. Consumers with the appropriate capacity to leave the service were unable to do so and staff interactions with consumers did not evidence consumers are treated with dignity and respect.

I have therefore decided the requirement is not compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |

Findings

Information in the Assessment Team report indicated the service did not demonstrate appropriate and informed consent, authorisations and risk and capacity assessments are completed for consumers subject to restrictive practices. The service did not demonstrate processes to individualise and review behavioural support plans (BSP) or monitor or record the effectiveness of chemical restraint. The service did not identify some consumers subject to seclusion, environmental, physical, chemical and mechanical restraint.

The Assessment Team report indicated staff did not demonstrate effective strategies are used to mitigate risks to consumers when using restrictive practices. Restrictive practice was used as a first line intervention due to a lack of knowledge of appropriate and individualised behaviour management triggers and strategies.

Clinical management did not demonstrate a clear understanding of restrictive practices or ensure effective processes are in place for oversight, completing risk assessments and obtaining informed consent.

The service initially identified a total of 12 consumers at the service as subject to a restrictive practice. However, following feedback from the Assessment Team, the service identified the following numbers of consumers as subject to a restrictive practice during the assessment contact:

* Seventeen consumers subject to chemical restraint. The Assessment Team report noted of these, 12 consumers were absent consent, assessment or authorisation; and 2 consumers had authorisation which had not been reviewed for 12 months.
* Twenty-two consumers subject to mechanical restraint of which 11 consumers did not have assessments, authorisations or consent.
* Five consumers subject to physical restraint with no risk assessments, authorisation or consent for one consumer.
* Twenty-nine consumers subject to environmental restraint, with no consent, risk assessments or authorisation for 26 consumers.

However, the Assessment Team noted 60 consumers were onsite and management and consumers said all consumers with the exception of one or 2 do not have access or knowledge of the keypad code to allow them to leave the service. Additionally, approximately 25 consumers’ rooms are located on the second floor which requires a code to either take the lift or stairs to the first floor. These consumers had not been identified as subject to environmental restraint.

The service did not identify any consumers subject to seclusion, however, a review of BSPs found 2 consumers had seclusion noted as a last resort behaviour management strategy in their BSPs. Documentation evidenced no risk assessment or informed consent were in place and one consumer representative said they were unaware of the consumer being subject to seclusion as a behavioural management strategy. The clinical managers said they were unaware of this inclusion in the BSPs.

The service provided a list of 23 consumers who have changing behaviours which include verbal and/or physical aggression. Following review of consumers’ documentation, observations by the Assessment Team and staff interviews, the Assessment Team report concluded the service did not demonstrate effective management of consumers’ changing behaviours, appropriate staff training and knowledge in relation to managing consumers’ behaviours and appropriate use of restraint as a last resort.

In response to the Assessment Team report, the service advised they employed an external consultant to complete the initial assessments and care plans of consumers including BSPs. The response advised staff were not fully cognizant of some details within the BSPs.

With respect to the 2 consumers noted to have seclusion listed as a behaviour management option in their BSPs, the service advised the BSPs had been redone by service clinical staff. The service advised while returning a consumer to their room was used to reduce agitation, the consumers were never unable to leave their room. The service expressly assured the Commission that seclusion and isolation is not practiced at the service either in relation to the 2 named consumers or any other consumers at the service.

The service advised of a number of actions taken since the assessment contact. For example, the service advised 25 BSPs had been reviewed and education provided to staff on each BSP individually. The reviewed BSPs had been completed by clinical management at the service in conjunction with staff. The response advised all current BSPs for consumers at the service would be reviewed. Service management have consulted with external clinical providers in relation to a review of all assessments and care planning processes.

All staff have been enrolled in DSA competency based training titled “Understanding Changed Behaviours” which will be completed by the end of 2024. Registered staff have also booked to complete Aged Care Industry Association training on recognition of restrictive practice. The response noted that prior to the assessment contact, staff had already received training in responsive behaviours, how to recognise escalating behaviours and how to de-escalate behaviours.

The Assessment Team report provided eight detailed examples of individual consumers whose care raised concerns regarding various aspects of their clinical care, and primarily in relation to the use of restrictive practices. I do not intend to go into the details of these examples other than to note they were important in informing my decision regarding this requirement. The response from the service partly addressed some of these concerns for each consumer, and also included information that provided context or outlined actions taken since the assessment contact to address concerns raised in the report in relation to these consumers.

One named consumer, however, does require comment in this report. The Assessment Team report indicated this consumer’s medication chart evidenced PRN midazolam injections were administered on 19 occasions between 26 June 2024 and 18 September 2024 for agitation*.* Interviewed clinical staff said the consumer is palliating and they aware of the use of midazolam for agitation and unsettled behaviour. Clinical staff could not explain specific individualised non-pharmacological strategies to manage her agitation. Clinical staff said they were not aware midazolam was being used as a chemical restraint because she was receiving midazolam for palliation. The Assessment Team could not find evidence in the progress notes or medication chart to demonstrate the midazolam was reviewed by her medical officer since 26 June 2024 or that midazolam was administered for palliation. Documentation did not evidence a palliation care pathway in the consumer’s file.

In response, the service advised the consumer is actively palliating and two days after the audit was reviewed by a hospital palliative team in association with Woodlands clinical staff. As a result, her medication chart has been amended to Midazolam for terminal agitation only and included oral Clonazepam for agitation and Ordine liquid for pain. The subcutaneous medications will now only be used when the consumer is unable to swallow liquid medications. The consumer’s palliative care pathway has been included in paper-based documentation.

The care and management of this consumer is of great concern due to what could be seen as the use of midazolam as a chemical restraint in the absence of clear documentation regarding the use of the drug for palliation. It is of concern the actions to address this were only taken in response to the assessment contact and had not been previously identified by the service.

In other areas of clinical care reviewed by the Assessment Team, the service did demonstrate effective processes for managing falls, wounds, pain and weight loss. The service did not demonstrate consistent processes for recording skin tears in the incident management system to accurately identify trends.

I note the confirmation in the service of some of the deficiencies identified in the Assessment Team report and I acknowledge the actions taken, or underway by the service to address these and other issues and concerns raised. I also note the service’s willingness to co-operate with the Commission’s processes and keep the Commission informed of progress in these matters, by supplying updated plans for continuous improvement (PCI) on a regular basis.

Following consideration of the above information, I am convinced the requirement is currently not compliant and the service will need to continue to take actions to address the identified deficiencies and demonstrate sustainable actions have been implemented to return the service to compliance.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not Compliant |

Findings

The Assessment Team report contained information which indicated the service could not demonstrate the service environment was safe, clean, well maintained and comfortable. The Assessment Team observed indoor and outdoor areas to be unclean, not well maintained and smoking areas were not suitably equipped with safety measures for consumer use. In addition, the Assessment Team identified renovation, storage and other areas pose a potential hazard and safety risk as they were not restricted to prevent consumers from accessing these areas. Interviews with consumers, representatives, staff and management confirmed consumers residing on the first floor cannot access the ground floor level independently or without staff supervision.

The Assessment Team observed the following instances where the service environment was not safe, clean or well maintained:

* Multiple communal bathrooms were observed with significant amounts of water on the floor. Care staff advised this is a result of washing down the bathroom after a consumer had used it, and cleaning staff will mop the water up in due course. Cleaning staff advised it is the responsibility of care staff to clean up water off the floor following consumer showers. The Assessment Team identified instances where consumers have sustained falls as a result of slipping on wet floors.
* Multiple outdoor areas including consumer balconies to have cigarette ash trays in place, despite not being designated smoking areas. In addition, these areas did not have safety equipment in place such as fire blankets or smoking aprons to minimise the risk of harm to consumers who are smoking. Management advised consumers are non-compliant with smoking in designated smoking areas.
* Curtains on the first floor of the service in the ‘high dependency unit’ appeared to be visibly stained by urine.
* The service’s outdoor areas were observed to be overgrown, with shrubbery and grass overflowing onto outdoor walkways creating a trip hazard for consumers.
* The service is currently completing ongoing renovations on particular rooms and construction is currently in progress in the first-floor wing. The Assessment Team observed rooms under construction were not secured from consumers access and construction materials were placed within the communal hallways of the service. In addition, the Assessment Team observed nails and other hazardous construction equipment on the floor of consumers’ communal area where consumers were walking with bare feet.

The Assessment Team report indicated consumers are unable to move freely within the service. All consumers (with one or two exceptions) were unable to move freely indoors and outdoors as they do not have access or knowledge of the lift code required to move between floors. Consumers and representatives confirmed they could not move freely and independently throughout the service.

The Assessment Team observed multiple instances where consumers were being prevented from leaving the high dependency unit, even though they were not consented to being under environmental restraint and instances where consumers were requesting/attempting to leave the service but were being prevented by staff.

The Assessment Team did not observe any outdoor area consumers could access which was not being used by consumers who smoke.

In response to the Assessment Team report, the service advised building contractors onsite had been informed of the requirement for appropriate barriers to be in place while work is undertaken. The works are expected to be completed by the end of October.

The code for the lift is now available inside the lift carriage for consumers who wish to go to the downstairs area. The code for the front door is now available beside the keypad and the process explained to consumers wishing to leave the service.

An audit of fire equipment has been completed, and additional items have been ordered to improve safety in the smoking areas.

All staff have been re-educated in the process that it is the responsibility of care staff effecting hygiene care to dry the bathroom floor when cares are concluded.

A replacement process will be put in place to phase out the use of cloth curtains particularly in the high dependency area where consumers may urinate in inappropriate locations.

In addition to the installation of new automatic front doors and the automatic easy release doors to the smoking deck the service will be installing a decorative fenced area at the front of the service which will be designated Non Smoking to provide a smoke free environment for consumers.

The service acknowledged a large number of consumers who have been addicted to nicotine and many other substances for a large number of years and that convincing those consumers to quit, reduce, use patches or gum is rarely successful. Many of the consumers who continue to smoke retain cognition and refuse to allow staff to manage their cigarette allocation. The response said this continues to be an area of great concern impacting the safety and lifestyle of consumers and staff alike.

The response advised a second nurses’ station has been put in place in the downstairs area to enable the RN to visually monitor consumers in the smoking area, dining room and lounge room of Wattle wing.

While I acknowledge the actions taken by the service to address the deficiencies recorded in the Assessment Team report, it is clear this requirement was not compliant at the time of the assessment contact, and it will take some time for some of the actions proposed by the service to be completed. I have therefore decided this requirement is not compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |

Findings

With respect to requirement 8(3)(b), information in the Assessment Team report indicated the service did not demonstrate an effective governing body is in place to ensure systems for accountability and promotion of safe and quality care and services for consumers.

Management stated they meet with the 2 directors fortnightly to discuss individual consumer’s clinical care as the directors are also the consumer’s treating medical officers. Management said they do not complete any reports on a weekly or monthly basis, although the directors are provided copies of the clinical indicators on a quarterly basis. Management said any SIRS, complaints or serious incidents are communicated verbally to the directors.

Management said the directors are in the process of expanding the Board and will engage independent members with meetings to start in October 2024. Management did not provide any further information of how the service would ensure the Board had a majority of independent, external members to meet their legislative obligations relating to provider governance.

Management said they have not established a quality care advisory body but have added an action to the PCI to establish a bi-annual meeting by November 2024. Management said a representative has agreed to participate as well as an external clinician. A review of the PCI identified this entry was recorded on 18 September 2024.

A review of clinical indicator documentation identifies it lists the number of incidents per section such as fall and falls with harm but does not provide trending or analysis or comparison to the previous quarter or a breakdown by month.

In response to the Assessment Team report the service advised the consumer advisory body will meet in December 2024 with 2 consumers and 2 consumer representatives willing to participate.

The directors have appointed three new external board members. The response said all three external members meet the requirements outlined in the governing body guidelines.

Clinical indicator documentation from the weekly clinical quality meeting will provide current clinical indicators in a more defined way to the weekly directors’ meetings. A combination of these reports will then be provided to the quarterly Board meeting. This will provide the directors information to participate directly in suggestions for improvements to care and services to the consumer.

I acknowledge the actions proposed by the service to address the identified deficiencies but note some of these are yet to be implemented and they will require time to be established as usual practice. I have therefore decided this requirement is not compliant.

With respect to requirement 8(3)(c), the Assessment Team report indicated the service has not demonstrated effective systems relating to information management, continuous improvement, workforce governance, regulatory compliance or feedback and complaints.

The service did not demonstrate systems were being used effectively to manage incidents, behaviour management or restrictive practices. Staff did not consistently demonstrate understanding or awareness of documentation processes or where/how to access consumer information such as BSPs.

The service demonstrated complaints and feedback are used to initiate improvements, however, the service has not demonstrated incidents are reviewed or analysed to identify service wide areas for improvement.

A review of the service’s PCI records areas for improvement identified through the current audit, a National Disability Insurance Scheme (NDIS) audit in August 2024 and complaint information. The PCI did not record any areas of improvement identified through incident trending, survey results or other means.

The service demonstrated systems are in place for rostering, required care minutes are being achieved and vacant shifts are filled. Management said due to the consumer cohort, agency staff are not used to fill vacant shifts rather internal staff are used or shifts are extended. Consumers and staff said they felt staffing was sufficient and vacant shifts are filled.

However, the service did not demonstrate staff are effectively equipped and trained to perform their roles specifically in relation to incident management, identification of abuse and neglect and behaviour management. Staff did not demonstrate an understanding of SIRS, restrictive practices and provided inconsistent processes for incident management.

The service has not demonstrated it is meeting the regulatory requirements in relation to restrictive practices, SIRS, provider governance or security of tenure. For example, at the time of the assessment contact, informed consent, authorisations and risk assessments had not been completed for 12 consumers subject to chemical restraint, 11 consumers subject to mechanical restraint, one consumer subject to physical restraint, 2 consumers subject to seclusion and over 50 consumers subject to environmental restraint. The service was unable to demonstrate restrictive practice is used as a last resort and consumers are appropriately assessed to identify the need for its use.

A review of consumers’ progress notes and incidents demonstrated the service was not identifying incidents which met reporting criteria for SIRS. Management said they are responsible for reviewing incidents with clinical management to identify when incidents meet reporting criteria. Management did not demonstrate a clear understanding of all reporting criteria including inappropriate sexual behaviour and emotional and psychological harm.

At the time of the assessment contact, the service had not established a consumer advisory body or quality care advisory body to adhere to legislative requirements for provider governance which were to be implemented as of 1 December 2023.

With respect to security of tenure, the Assessment Team report explains in significant detail, a situation involving a named consumer who had initially been asked to leave the service due to behaviours impacting upon the safety and wellbeing of other consumers, but who had subsequently been transferred to a residential tenancy agreement within the service. It is undoubtedly a complex and difficult situation with issues concerning the cognitive capacity of the consumer to make decisions and his level of care needs. It is debatable as to whether or not the consumer understood the full ramifications of signing a contract for an unfunded bed including the loss of any clinical care and loss of security of tenure.

In response to this issue, the service advised the consumer’s residential tenancy agreement which includes room, furniture, bedding, food, cleaning and washing and the offer should their care needs increase to be transferred to a government funded bed and receive ongoing clinical management. The consumer’s representative stated they did not believe the consumer has capacity but the consumer refuses to involve their representative in any decisions around their life. The service has suggested to the consumer’s representative obtaining a Gerontologist report around the possible changed level of capacity would be helpful if they feel the latest cognitive assessment is inaccurate. The service maintains contact with both the consumer (on a daily basis) and the representative fortnightly to ensure any changes are identified.

The Assessment Team report indicated some consumers were satisfied with the outcome when they raised feedback and the service captures feedback and complaints in an electronic complaints management system, which all staff can access to document feedback. A review of documented complaints indicates actions are taken in response to documented complaints.

However, the service did not have any information available to consumers displayed in the service or in the newsletter regarding how to make complaints. The Assessment Team did not observe any forms or box available for consumers to make complaints. Management said a QR code is available for consumers and family members to make complaints, however the Assessment Team did not observe any QR codes displayed or information in relation to how to make complaints.

The service did not demonstrate systems in place to ensure accountability or oversight of complaints by the governing body. Although management said the directors are informed verbally of complaints, no documentation, trending or outcomes are formally reported.

In response to the Assessment Team report the service advised a plain speech handout had been re-issued to all consumers with details on how to make complaints. Information signs which had been removed throughout the service on how to make complaints have now been laminated and replaced. A detailed outline on how to make complaints is included in the consumers handbook and the residential care agreement. Feedback and Complaints will remain an agenda item for all meetings and a red mailbox for consumer feedback is available at the front door of the service should anonymous issues need to be raised.

Following consideration of the above information, I am persuaded by the extensive examples provided in the Assessment Team report that the service is not compliant in this requirement and has not demonstrated effective systems relating to information management, continuous improvement, workforce governance, regulatory compliance or feedback and complaints.

With respect to requirement 8(3)(d), the Assessment Team report includes information which indicates the service was unable to demonstrate effective implementation of processes to manage and prevent incidents. Staff were unable to discuss high impact and high prevalence risks, and/or how to identify abuse and neglect of consumers. Management failed to demonstrate effective management of consumer risks and incidents, including adhering to mandatory reporting requirements.

The service could not demonstrate effective management of high impact and high prevalence risks to consumers including but not limited to consumer behaviour management and the use of restrictive practice.

The Assessment Team identified gaps in the identification and reporting of serious incidents, including those with critical risks to consumers’ clinical wellbeing. For example, the service relies on care staff to identify incidents and escalate to registered staff for review. However, care staff did not demonstrate a shared understanding of what constitutes an incident. In addition, care and registered staff could not identify the specific kinds of incidents which are reportable under the SIRS.

The Assessment Team noted a number of incidents constituting a SIRS report which were not identified or reported as per legislative requirements. This was not disputed in the service’s response to the Assessment Team report.

During the assessment contact, management acknowledged gaps in the service’s ability to identify, document and report incidents as appropriate. In their response, the service provided an updated PCI with actions to be completed following feedback pertaining to serious incident identification and reporting.

Management described their use of an incident management system and provided their incident management policy. However, the service was unable to demonstrate compliance with their incident management policy. The service maintains an incident management policy and procedure which stipulates all incidents must be investigated through an appropriate method (such as a root cause analysis), assessed, responded to and a corrective action taken to reduce the risk of the incident occurring again. However, gaps were identified in staff knowledge surrounding what constitutes an incident. When prompted, most staff advised they would document incidents in progress notes rather than an incident report.

Management advised they do not currently have a process to trend and analyse incidents at a service wide level. Each week, clinical staff discuss incidents if one consumer has experienced multiple incidents, however, do not trend or discuss incidents by category.

The Assessment Team reviewed the service’s clinical indicators which evidenced incidents are only recorded as a number per category. These figures do not include analysis or investigation information.

The Assessment Team reviewed the service’s incident register which evidenced all incidents did not have investigations, assessments, follow up or corrective actions taken to reduce the risk of reoccurrence. All incidents recorded only listed incident summaries and if the incident had been closed off.

The Assessment Team identified a number of incidents in consumer progress notes which had not been flagged as incidents in the service’s incident management system.

In responding to the Assessment Team report, the service advised of actions being implemented to address the identified deficiencies including management having hand over sessions with staff encouraging them if unsure to enter behaviours, skin issues, continence issues as incidents. Care staff have been advised that only registered staff will commence incident forms and received retraining on what clinical indicators need to be reported to the registered nurse immediately. Incidents will be flagged on a daily basis for all managers who can investigate and move incidents forward in a timelier manner and in the area of clinical monitoring. Refresher incident management training is scheduled for all staff before the first week in November 2024.

The service advised all staff have completed the Commission’s online education sessions regarding Restrictive Practice and the Serious Incident Response Scheme (SIRS). The service advised authorisation forms are now in place for consumers subject to restrictive practices.

Following consideration of the above information, I am persuaded the service does not currently have an effective incident management system for identifying, managing and reporting adverse incidents involving consumers. I have therefore decided the requirement is not compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)