Performance

Report

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| Name of service: | Wyoming Nursing Home |
| Service address: | 47 Grosvenor Crescent SUMMER HILL NSW 2130 |
| Commission ID: | 2355 |
| Approved provider: | Wyoming Nursing Home Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 1 November 2022 to 4 November 2022 |
| Performance report date: | 12 December 2022 |

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 Wyoming Nursing Home (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

The following information has been considered in preparing the Performance Report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, 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 30 November 2022.
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances determination dated: 26 August 2021; 25 February 2022; 18 August 2022.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

**Areas for improvement**

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

Requirement 1(3)(a) The approved provider must demonstrate that consumers dignity and respect is not compromised due to the intrusion of other consumers into their rooms.

Requirement 1(3)(f) The approved provider must demonstrate that consumer’s privacy is respected by effectively managing consumers with behaviour concerns.

Requirement 2(3)(a) The approved provider must demonstrate assessment and planning for consumers at the service includes the consideration of relevant risks, particularly managing behaviours of concern and falls.

Requirement 2(3)(e) The approved provider must demonstrate that documentation reflects a regular review for effectiveness when incidents impact on the wellbeing and safety of the consumer and others.

Requirement 3(3)(a) The approved provider must demonstrate that personal and clinical care the service delivers is safe and right for consumers.

Requirement 3(3)(b) The approved provider must demonstrate that the high impact or high prevalence risks associated with behaviour management and falls are effectively managed.

Requirement 3(3)(g) The approved provider must demonstrate the service is practicing precautions to prevent and control infections.

Requirement 4(3)(a) The approved provider must demonstrate that the service is effectively supporting the daily living of consumers who wander, display challenging behaviours and are unable to initiate activities for their wellbeing and quality of life.

Requirement 4(3)(f) The approved provider must demonstrate that the feedback from consumers in relation to meals is considered and meals are presented in an appetising manner, and the service offer meals that are varied and suitable quality and quantity.

Requirement 5(3)(a) The approved provider must demonstrate that wayfinding throughout the service does not negatively impact on consumers with a cognitive impairment wandering the halls and entering other consumer’s rooms.

Requirement 5(3)(b) The approved provider must demonstrate that consumers are free to move from different floor levels to access different areas of the service.

Requirement 6(3)(a) The approved provider must demonstrate that consumers and representatives are supported to provide feedback and make complaints.

Requirement 6(3)(c) The approved provider must demonstrate that the service takes appropriate action to resolve complaints.

Requirement 6(3)(d) The approved provider must demonstrate that it has processes in place to review feedback and complaints to continuously improve the quality of care and services for consumers.

Requirement 7(3)(a) The approved provider must demonstrate the service has sufficient staff at the service to ensure the delivery and management of safe quality care and services

Requirement 7(3)(c) The approved provider must demonstrate that staff have the skills and knowledge to effectively perform their roles and that new staff commencing at the service have effective orientation into their roles.

Requirement 7(3)(d) The approved provider must demonstrate that staff are provided with sufficient education including mandatory training to effectively perform their roles.

Requirement 7(3)(e) The approved provider must demonstrate the service has effective systems and processes to monitor and review the performance of each member of the workforce.

Requirement 8(3)(a) The approved provider must demonstrate consumers are encouraged to participate in their day-to-day care and have a broader representation in the planning of their care and services.

Requirement 8(3)(b) The approved provider must demonstrate the organisation’s governing body is provided with sufficient information in a format to be effectively involved in or be accountable for the planning, delivery and evaluation of care and services

Requirement 8(3)(c) The approved provider must demonstrate the organisation’s systems for information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints provides sufficient, consistent or readily available information for staff and management to perform their roles effectively.

Requirement 8(3)(d) The approved provider must demonstrate that the organisation has effective risk management system and practices in place at the service relating to managing risks to the health, safety and well-being of consumers and that identified risks are effectively evaluated to reduce or remove the risks that match the level of risk and how it is affecting consumers.

Requirement 8(3)(e) The approved provider must demonstrate the organisation has an overarching clinical governance framework that includes key elements of clinical governance.

**Standard 1**

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Non-compliant |

**Findings**

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

The following two requirements were found to be non-compliant:

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

The Assessment Team interviewed consumers and representatives and found that some felt that they are treated with dignity and respect and that their identity, culture and diversity are valued as individuals. However, some consumers said that their dignity and respect was compromised as consumers wander freely into their rooms and remove their personal items. Two consumers said they have no choice but to lock their doors as they feel they have no control over who frequents their rooms, and some consumers say they have been assaulted.

One consumer said ‘care staff are kind and respectful, they understand what we need and what makes us happy, but the biggest problem is our privacy and respect, I don’t want other consumers coming into my room without my consent, they are often aggressive and help themselves to my personal items’.

The Assessment Team observed staff were generally observed to be treating consumers with respect and in a caring manner, and spending time one on one with consumers helping and comforting those less capable during dining service.

Language used in the care documentation was respectful and evidence shows that care documentation reflects personal and cultural preferences and were completed together with the consumer and their families and friends which was confirmed during conversations with representatives.

Consumer and representative feedback, staff interviews, and observations made by the Assessment Team show consumers’ personal privacy is not well respected due to consumers with cognitive impairment frequently wandering into other consumers rooms. The service has also self-identified that consumer privacy is not respected because of this occurring.

Care staff interviewed said consumer’s privacy is compromised as there is not always a private place for consultation of confidential matters.

Privacy and dignity for consumers with shared rooms with four occupants is compromised as they are separated by curtain partitioning providing nowhere for confidential discussions or treatments to occur and this allows for others to just walk in when personal care is being delivered.

Generally, staff demonstrated respect for consumers’ privacy by knocking and calling out their names before entering consumers’ rooms, closing curtains and doors when providing care, speaking privately behind closed doors where possible, and not talking to consumers about other consumers.

However, during the Site Audit the Assessment Team observed a consumers care plan document attached to the wall in his room, therefore not ensuring consumer personal and health information is kept confidential.

The approved provider responded to the Assessment Team’s report and provided a copy of the Continuous Improvement Plan and Training Plan. The provider has advised that they have initiated a number of rooms changes for the named consumers who have been impacted by the behaviours of wandering consumers or the wandering consumers, this is effective immediately. The provider has also advised that they have apologised to the consumer and representatives and provided counselling and support to any affected consumer. The provider has liaised with dementia Services Australia and engaged the services of a Behaviour Support practitioner and Senior Nurse Advisor to oversee the implementation of improvement actions and follow up.

I acknowledge the immediate actions that the provider has initiated, however feel that it will take some time to demonstrate sustained compliance with this requirement.

I find that the approved provider is non-compliant with these requirements.

The following requirements were found to be compliant:

* Requirement 1(3)(b)
* Requirement 1(3)(c)
* Requirement 1(3)(d)
* Requirement 1(3)(e)

The Assessment Team interviewed consumers and representatives who described how staff respect their culture, values and diversity and how this informs the daily provision of care and services. Care planning documentation reviewed reflected consumers’ history, cultural needs, interests and preferences. Staff described how they supported consumers to maintain their culture and what was important to them.

Most consumers and representative expressed satisfaction that consumers could exercise choice and make decisions about their care and services, while being supported to maintain relationships that are important to them. The service was able to demonstrate that each consumer is supported to exercise choice and maintain their independence by making decisions according to their preferences. Consumers are supported to make their own decisions about the way care and identify who they would like to be involved in their care and services. Representatives provided feedback of how they can be involved and are made aware if there is any change in the consumer’s condition.

The service was able to demonstrate consumers are supported to take risks to enable them to live the best life they can. Staff could describe instances where a risk assessment was required and how consumers are supported to understand the risks and benefits of specific activities. Consumer risk assessments have been completed to support consumers undertaking risks related to food choice, mobility, alcohol consumption, smoking, external outings and restraints. One consumer spoke of the need to remain independent, mobile and active and how the staff support he consumer to live the best life by giving the consumer small tasks and jobs, to feel a purpose.

The Assessment Team observed dignity of risk assessments completed for consumers to frequent inside and outside the facility with motorised chairs supporting then to take risks to enable them to live the best lives they can. The consumers enjoy the independence and mobility the electronic chairs provide whilst considering and mitigating risks.

The Assessment Team found that most consumers and their representatives expressed satisfaction that the information they receive is current, accurate, timely, communicated clearly, and is easy to understand and enables consumers to exercise choice. The service notice boards in the communal and dining areas were observed to communicate menu options, current activities program and internal feedback forms. However, the Assessment Team observed that the activity schedule daily meal menu and other information are only available in English. This was raised with management and addressed during the Site Audit.

Representatives provided feedback that they receive all the information they need and said ‘management keep consumers and their families up to date, for example, during the COVID-19 pandemic they provided updates all time. We also get a regular newsletter and minutes from the meetings, so we know what’s going on. They call me and email me if there are any concerns with medical issues or in general’. Another representative said that the staff take the time to explain things to both of us, and they let me know if anything changes.

**Standard 2**

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

**Findings**

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

The following two requirements were found to be non-compliant:

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

The Assessment Team reviewed care planning documentation of sampled consumers and conducted interviews with consumer representatives, which indicates assessment and planning for consumers at the service does not include the consideration of relevant risks, particularly managing behaviours of concern and falls, resulting in the delivery of care and services that are not safe and effective.

Care planning documentation, including a behaviour support plan for one consumer details intrusive and aggressive behaviour which is not being managed. Staff said the strategies provided are not working. Incidents are documented in the progress notes, however there are no new risk assessments following the latest incident. This was discussed with management who acknowledged there were no additional strategies in place.

The Assessment Team identified that the service has procedures to review care plans however, for consumers with behaviours of concern and those experiencing falls, documentation did not reflect a regular review for effectiveness when incidents impact on the wellbeing and safety of the consumer and others.

The service’s clinical indicators fall data reflects a consumer who has had a number of falls between September and October 2022. The consumer was reviewed by allied health after each fall; however, the last fall risk assessment was completed in September 2022 despite having several falls in October and allied health review. There is no documented evidence of escalation of risk or monitoring the risk of falling after each incident, despite scoring as a high falls risk. This was despite knowledge that management provided fall data which portrays falls are increasing at the service. There were an increasing number of falls between July to October 2022. This was discussed by management who said falls management was on their Continuous Improvement Plan.

The approved provider responded to the Assessment Team’s report and provided their Continuous Improvement Plan and Training Plan. The provider advised that they would commence updating care plans to address consumer’s needs, goals and preferences and their current circumstances. The provider advised that they would provide staff with education at orientation and throughout their employment to address consumer’s changing condition. The provider has also advised they have met with the named consumers and representatives to discuss the movement of consumers with behaviours of concern and apologised for the impact to consumers.

I acknowledge the providers response and actions taken, however find that it will take some time to demonstrate sustained compliance.

I find that the approved provider is non-compliant with these requirements.

The following three requirements were found to be compliant:

* Requirement 2(3)(b)
* Requirement 2(3)(c)
* Requirement 2(3)(d)

The Assessment Team interviewed consumers and representatives who indicated they have been given the opportunity to discuss their consumers’ current care needs, goals and preferences including advance care or end of life planning. Sampled consumers’ care planning documents include what is important to individual consumers and how they want their care delivered, and end of life care plans are in place. Management said information on advance care planning is discussed on entry to the service and consumers and their representatives can further discuss this during family case conferences. Staff can describe what is important to consumers and how they want their care delivered.

Sampled consumers and representatives said they feel they are partners in care with the service. Staff said they involve the consumers and representatives in planning for care and other health practitioners where appropriate such as physiotherapist, medical officers, dietitian, speech therapist and dementia specialists. Sampled consumers files reviewed reflect evidence the consumer is a partner in their care and who they choose to have involved in their assessment.

Most consumers and representatives sampled felt they are well informed about the outcome of assessment for their clinical and personal care and had no complaints in relation to this requirement. Some consumers and representatives had difficulty recalling seeing their care plan and if assessments had occurred. Management advised the Assessment Team the service is now encouraging consumers and their representatives to sign the care plans after discussion of assessments and planning, and the service has a folder containing copies of summary care plans for easy access for consumers and representatives to sign. Most consumers and representatives sampled know care plans are readily available. Consumer representatives said case conferences occur with staff and care and services are discussed. Consumer files review demonstrated care plans for consumers are in place.

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

**Findings**

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

The following three requirements were found to be non-compliant:

* Requirement 3(3)(a)
* Requirement 3(3)(b)
* Requirement 3(3)(g)

The Assessment Team interviewed consumers and representatives and found that some provided feedback they are not satisfied the personal and clinical care the service delivers are safe and right for consumers. Most representatives interviewed told the Assessment Team they were not happy with the personal hygiene of their consumers, nor the frequency consumers were showered as opposed to their preferences.

The Assessment Team received feedback about staff not assisting the consumers with their meals and drink, with some staff putting meals down in front of the consumers and leaving and related weight loss, without monitoring food intake. The Assessment Team observed a smell and a used bed pan still sitting in the commode chair beside one consumer’s bed during handover. The bed pan was emptied by staff after prompting. The Assessment Team observed consumers wandering around the service and intruding into other consumer’s rooms and privacy.

Management provided the psychotropic register which reflects all sampled consumers having a consent form for the chemical restraint and a behaviour support plan (BSP) in place. The service advised the Assessment Team none of the consumers are on environmental restraint. However, the Assessment Team observed there are some consumers who live on the first floor and cannot access the keypad for the lift to go downstairs and outside. Management acknowledged the issue and advised the Assessment Team they were going to follow it up.

Most of the sampled consumer representatives were concerned about the safety of their consumers from those consumers with behaviours of concern who wander into other consumers’ rooms and are sometimes verbally and physically aggressive towards other consumers. They were not satisfied the service was effectively managing these behaviours nor were they convinced their consumers were safe. The Assessment Team identified deficits in the management of high impact or high prevalence risks associated with behaviour management and falls. A lack of clinical governance was evident when reviewing consumers with high impact or high prevalence risks in relation to behaviour management and the safety of other impacted consumers. Staff members indicated they found it difficult to keep an eye on wandering and intrusive consumers due to time pressures.

Staff said the strategies documented in the behaviour support plan for some consumers were not working nor were they effective. This was discussed with management who acknowledge there were no additional strategies in place. Risk assessments are completed but there is no evidence they are reviewed, and management confirmed this when it was discussed with them.

The Assessment Team found that the service has an up-to-date outbreak management plan and have revised isolation requirements to prevent and control infection. The service’s outbreak management plan was last reviewed in July 2022. Management advised they have had 6 outbreaks in the last two years mostly as a result of the high number of shared rooms. The revised outbreak management plan allows for affected consumers to isolate in shared rooms with other consumers and have designated bathroom facilities in the areas affected by the outbreak. However, the Assessment Team identified that the current Infection control lead is on leave and there is no replacement at the service. Documentation for staff vaccinations was not available to the Assessment Team as it was in the electronic system.

Observations of the service’s environment indicate that the service is not practicing precautions to prevent and control infections. The Assessment Team identified unlocked clinical bins in an unsecured area. After discussion with management some bins were moved to a small locked wooden cage and the service is arranging for locks to be placed on the remaining bins. It was noted that the doorway leading to the waste management area is also the entrance accessed by hospitality services including laundry, clinical and general waste and food deliveries. The clinical nurse adviser advised that the organisation was aware of this issue, and this will be considered with the upcoming renovations. It was also observed that shared bathrooms are not always cleaned in a timely manner after unassisted use by consumers. Management advised that responsibility for this is for care staff during personal care or cleaning staff during routine cleaning. Overflowing laundry bags were observed in laundry trolleys on both levels.

Full and overflowing waste bins were observed under handwash stations with one observed with swabs lying on the floor. No wipes were readily accessible for the cleaning of shared lifters. The Assessment Team observed individual slings left across shared lifters. Staff say they are usually hung up or in consumer’s rooms. A management team member was observed during meetings with the Assessment Team to constantly be removing their mask to cough into their hand and then replacing the same mask and not using any sanitiser once mask was replaced.

The approved provider responded to the Assessment Team’s report and advised that they have commenced a full review of the feedback provided and have held conversations with each representative to address their concerns. The Continuous Improvement Plan has been updated to address areas of improvement and a training plan is in place to provide education to staff. Changes to the keypad system are in progress to ensure that consumers can use the lifts independently and access external areas. The provider has advised that since the Site Audit a strategy to address stability and sufficiency in staffing has been developed to improve continuity of care with more permanent staff to assist in managing incidents.

I acknowledge the providers response and actions, however, find that these measures will take some time to reflect compliance.

I find that the approved provider is non-compliant with these requirements.

The following four requirements were found to be compliant:

* Requirement 3(3)(c)
* Requirement 3(3)(d)
* Requirement 3(3)(e)
* Requirement 3(3)(f)

Consumer representatives sampled indicated the services discusses end of life preferences with consumers and their representatives if they wish to do so. Management said the service offers consumers opportunities to provide details of their wishes regarding end-of-life care on entry to the service and ongoing. Management said the service receives specialised palliative care support via a palliative clinical nurse clinician from the Royal Prince Alfred Hospital outreach team. All sampled consumer files reviewed reflect some discussion and documentation of end-of-life care and wishes had occurred. The service demonstrates the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

Interviews with sampled consumer representatives indicate the service recognises deterioration or a change in a consumer’s mental, cognitive or physical function and escalates care in a timely manner. Care staff explained how they report changes in consumers condition to nursing staff and confirmed nursing staff follow up. Nursing staff said they complete a head-to-toe assessment and escalate to the doctor, at the same time notifying families and management.

The service demonstrates information about the consumer’s condition needs and preferences is shared within the organisation and with others where responsibility for care is shared. Overall, sampled consumer representatives reported staff know the consumers and their care needs well and information about their care needs is shared. Staff said they get relevant information about each consumer’s care through handovers, via email, by word-of-mouth face to face and from consumer care documentation.

The Assessment Team found that the service demonstrated that referrals are being made to specialist organisations and individuals who are better able to provide the consumer the particular care they need in consultation with consumers and their representatives. Consumer representatives sampled confirmed the involvement of other health care providers, and referrals to external services if needed by the consumer and that they were consulted. Sampled consumer care notes show evidence of referral to and input by specialist services including allied health professionals and wound specialist.

**Standard 4**

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

**Findings**

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

The following two requirements were found to be non-compliant:

* Requirement 4(3)(a)
* Requirement 4(3)(f)

The Assessment Team identified the service does not effectively support the daily living of consumers who wander, display challenging behaviours and are unable to initiate activities for their wellbeing and quality of life. Overall consumer representatives gave positive feedback regarding how staff support their relative’s independence, well-being and quality of life, given many consumers live with cognitive impairments, however several commented that consumer behaviours are having a direct impact on other consumers residing at the service.

The Assessment Team interviewed consumers and representatives who provided feedback including dissatisfaction with the activities offered at the service and there was little to do, other than walking the halls of the service each day. This was observed by the Assessment Team. Other consumers provided examples of consumers coming into their rooms and how their personal items go missing. One consumer stated that tissue paper is jammed in the lock and the table against the door to prevent other consumers entering.

Care planning documentation shows all consumers have a lifestyle care plan; however, the sampled care plans do not consistently identify supports for daily living to optimise the quality of life for consumers living with dementia and for those consumers who wander and intrude into the space of others.

The Assessment Team noted that lifestyle staff know the consumers by face and name and were able to explain what individual consumers likes and preferences were regarding lifestyles choices, needs and preferences. However, consumers who do not attend or unable to participate in group activities due to their behaviours did not have meaningful activities and engagement occurring.

The Assessment Team observed consumers wandering into other consumers’ space. The failure to identify and provide each consumer with services and supports that are tailored to their individual needs, goals and preferences compromises their safe and effective support for the best possible level of independence, health and well-being and for quality of life in their daily living.

The Assessment Team identified the service has an onsite chef and catering staff that prepare meals onsite at the service, catering services are contracted by the service. The menu offers consumers one warm or cold option for breakfast and 2 lunch options, which includes one vegetarian option. However, the menu states ‘vegetarian dish of the day’ but does not state what the vegetarian meal is, and this meal option was not displayed on the menu board in the 2 dining rooms at the service and was not on offer to consumers. The menu has only one option for dinner meals, when asked how they cater to all consumers preferences when serving food, a consumer dislikes, for example, chicken or fish, the chef said they serve other foods like vegetables that didn’t include the chicken or fish, or they would offer the consumer a sandwich.

Most consumers sampled provided negative feedback about the meals at the service and indicated that meals were always served cold, were not presented in an appetising manner, and the service did not offer meals that are varied and suitable quality and quantity.

Consumers provided feedback including that they will often skip meals because they don’t like the food on offer and that the meals that are clearly marked not to be served to a consumer is still served. Consumers advised that meals lack flavour and are always served cold, including drinks, for example, cold cups of tea and cold porridge. Consumers advised that they often feel hungry because ‘there is not enough food served up at most meals.’ One consumer said they are happy with the breakfast meal options but said there are no meal options for lunch and dinner and said, ‘you get what your given’. Two consumers said the food was always served cold and not enjoyable.

Catering staff said the service had recently implemented a new summer menu but did not have any information about how consumers were involved in this process, when asked if they attend the food focus meetings, they advised they had started at the service approximately 2 months ago and said they had not attended any meetings to seek feedback from consumers. Management said the service collects feedback about food from consumers daily, however management said this has not been documented. When asked if consumers were involved and a consultation process took place with consumers before the menu was implemented, management could not provide the Assessment Team with any documented evidence that this occurred.

When the service was asked by the Assessment Team about complaints about the food, staff indicated that the consumers who have complaints have meal plans in place and had been offered alternative menu options. However, feedback from the consumer’s representative was that these meal options were not always being implemented.

The approved provider responded to the Assessment Team’s report and advised that education will be provide to staff in relation to infection control, correct use of PPE and antimicrobial stewardship. Consumer who had limited mobility due to wheelchairs have been moved into rooms that are better suited to their needs. The provider has met with the catering services to implement strategies with food surveys, food focus groups and resident trays have been updated with their likes and dislikes and type of diet. Assessments will be reviewed to address lifestyle activities to include more meaningful activities for consumers with behaviours of concern.

I acknowledge the providers response and Continuous Improvement Plan; however, these actions will take some time to reflect compliance and many of the plans for improvement are listed to be reviewed.

I find that the approved provider is non-compliant with these requirements.

The following five requirements were found to be compliant:

* Requirement 4(3)(b)
* Requirement 4(3)(c)
* Requirement 4(3)(d)
* Requirement 4(3)(e)
* Requirement 4(3)(g)

The Assessment Team interviewed consumers and representatives and found overall consumers felt supported emotionally by staff. Staff described their practices which support consumers’ emotional, spiritual and psychological wellbeing. Documentation in care plans generally described the supports that are important and available to consumers.

Staff advise that consumers involved in incidents receive emotional support from staff, however this is not formally documented in consumer records. Lifestyle care plans sampled included information about consumers' religious background, preferences for emotional support and the people the consumers want to have involved in their care. Where consumers are inclined to keep to themselves, care planning documents reflect these preferences.

The Assessment Team found that most consumers said they were supported to do things of interest to them. Staff interviews, documentation review and observations support that consumer’s needs are identified in relation to their interests. Lifestyle staff provided examples of how they support consumers to participate in things of interest to them and to connect with others outside the service.

Consumers indicated there was enough support available in the lifestyle program for them to be able to do things of interest to them, both within the service and in the community.

Consumers and representatives interviewed said staff members generally know their needs and preferences regarding services and supports for daily living and they do not have to continually explain them to staff. However, one consumer said recently there has been a lot of new staff at the service and they can take time to get to know them and their preferences for care.

Clinical and care staff interviewed said information about the consumer’s condition, needs and preferences is communicated through staff handovers, consumers care plans, progress notes and one to one conversation. Hospitality staff were able to describe how clinical staff communicate dietary changes for consumer’s and how it is the responsibility of the hospitality staff to update the consumer’s dietary folder located in the kitchen.

A review of care planning documentation of sampled consumers identified adequate information and communication with others where responsibility for care is shared and consumer preferences, for example, dietary preferences, individual activity plans and handover sheets were reviewed by the Assessment Team. Staff were found to be knowledgeable about information contained in this documentation.

The service demonstrated timely and appropriate referrals of consumers to other organisations, individuals and providers of other care and services. Consumer’s care planning documentation provided evidence that the service collaborates with external providers to support the diverse needs of consumers. Management said referrals are made to the NDIS, DSA, older persons mental health team and geriatricians.

The Assessment Team found that consumers felt safe when using the service’s equipment and said it was easily accessible and suitable for their needs. Consumers said they were comfortable raising issues if equipment needed repair and knew the process for reporting an issue. Equipment used for activities of daily living were observed to be safe, suitable, clean and well-maintained.

Consumers reported having access to mobility aids, which are suitable and clean, to assist them with their daily living activities. However, during the Site Audit the Assessment Team observed one consumer’s mobility walker that appeared to be dirty, and the consumer advised that no one cleans it.

**Standard 5**

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

**Findings**

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

The following two requirements were found to be non-compliant:

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

The Assessment Team observed poor wayfinding throughout the service which negatively impacts on consumers with a cognitive impairment wandering the halls and entering other consumer’s rooms. The Assessment Team observed consumers that appeared confused and lost and requiring directional assistance, with limited or no staff assistance being provided.

The Assessment Team observed minimal communal spaces for socialisation throughout the service other than the dining room and lounge area on both levels at the service, an outdoor covered rotunda with outdoor seating, a small outside Zen area (located on level 1) and a small area with a café that has been newly implemented. However, the café is not in use and was blocked off (with rope) to consumers during the Site Audit. As a result, there are two main communal areas that are being used by consumers and were observed to be overcrowded at different times, especially during activities and mealtimes. Management advised the building is not purpose built and they are in the early stages of project planning for a whole new refurbishment of the building, including consumer rooms.

The Assessment Team observed consumers wandering the halls and entering other consumers rooms, staff were not always present to redirect the consumers.

The Assessment Team observed that consumers were not supervised in the outdoor area at the service and there was very little or no supervision in the dining/living communal areas at different times throughout the day. The Assessment Team had to get assistance on behalf of consumers on several occasions during the Site Audit.

There was very limited visible wayfinding throughout the service. Hallways and consumer’s doors are all the same colour with a photograph and name of the consumer located on the wall beside their door. There is no picture signage visible for the dining/lounge area or shared bathrooms/toilets. This issue was raised with management, and they advised the Assessment Team that there was picture signage available, but consumers had removed them. Management advised there will be permanent wayfinding signage implemented as part of future refurbishments.

The Assessment Team observed the service environment to be clean and well maintained most of the time. Cleaning and laundry services are outsourced, and from consumer representatives’ feedback and observations by the Assessment Team, seem to be effective. Most consumer’s rooms were clean and tidy. However, some consumers rooms appeared they needed cleaning and were needing walls repainted.

The Assessment Team observed one consumer’s room had what appeared to be stains and food on the wall adjacent to the bed and another consumer whose room appeared to be cluttered because they like to collect different items and store them in their room. Another consumer’s room has paint peeling patches on the wall that the consumer looks directly at when resting in the bed or chair, and said, ‘it’s not very nice to look at’ and said, ‘I don’t really expect anything more’.

Consumers with cognitive impairments residing on level one and the ground level, need assistance from staff to move from different floor levels to access different areas of the service via the lift with an access code in place. The behaviour of some consumers is also impacting on the service environment being safe for all consumers in the service. One consumer advised that they don’t feel safe and it’s a dangerous place, saying that the other consumers with behavioural issues are often violent and unpredictable.

The Assessment Team observed one consumer, calling loudly for staff to help get into the lift which has restricted keypad access, so the consumer could access the lower floor, no staff attended. The Assessment Team had to find a staff member to assist the consumer with lift access. The Assessment Team also observed a consumer with physical limitations unable to reach the sensor button to open sliding doors to access the outdoor area at the service and was assisted by another consumer and the maintenance officer. Not all consumers on the ground floor can easily access the only exit leading to an outdoor space. Some have a long distance around several winding corridors to be able to access the area. Management confirmed this was an issue and hope to address this during the renovations.

The approved provider responded to the Assessment Team’s report and advised that they will undertake an analysis of consumers’ rooms in relation to potential consumer movement into more suitable areas within the service to address behaviours of concern and intrusive behaviours. A strategy to address stability and sufficiency in staffing will be developed to ensure continuity of care with more permanent staff. As part of the planned refurbishment, signage has been designed to keep signs simple for consumers to understand and assist with wayfinding. Changes to the keypad are in progress to allow consumers to move more freely throughout the service.

I acknowledge the providers response and planned actions, however, find that this will take some time to reflect compliance.

I find that the approved provider is non-compliant with these requirements.

The following requirement was found to be compliant:

* Requirement 5(3)(c)

The service has processes in place to ensure furniture, fittings and equipment are safe, clean and well maintained. This includes cleaning and maintenance schedules.

The Assessment Team interviewed consumers who said they were satisfied with the cleaning of their rooms, the general service environment and their equipment. Consumers who used four-wheeled walkers or wheelchairs to mobilise said they felt safe when using this equipment. Consumers said they felt their equipment was suitable for their needs.

The furniture, fittings and equipment were observed by the Assessment Team to be generally clean, maintained and used safely.

The Assessment Team reviewed the maintenance and cleaning logs and identified issues raised by consumers/ representatives or staff are responded to in a reasonable time frame. However, one consumer informed the Assessment Team that the call bell had not been working for a period of 6 weeks. The Assessment Team raised this issue with management and the maintenance officer, and they informed the Assessment Team that the call bell had been checked by the maintenance officer and was found to be working each time. Maintenance records showed that the job had been logged and had been attended to each time the issue was reported. On the 3rd day of the Site Audit the Maintenance officer informed the Assessment Team that he would be replacing the cord and the call bell button for the consumer.

**Standard 6**

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

**Findings**

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

The following three requirements were found to be non-compliant:

* Requirement 6(3)(a)
* Requirement 6(3)(c)
* Requirement 6(3)(d)

The Assessment Team interviewed some consumers and representatives who said they felt supported to provide feedback and make complaints and felt comfortable doing so. Staff were able to describe how they assisted consumers to make complaints. However, some representatives said they were not supported to provide feedback and make complaints. Whilst there is some written material and feedback boxes at the service to support consumers to make complaints, there are no Commission brochures or posters ‘I have a concern” in English or other languages despite several different languages being spoken in the home. There were no brochures or accessible information regarding advocacy services such as OPAN to assist consumers if they wish to provide feedback or make complaints.

Some consumers and representatives commented that they were not supported to provide feedback and were not aware of the external complaints processes. One representative said they were not aware of external complaints information as there is a language barrier with staff not speaking fluent English and consumers who have reverted to their original languages. One consumer advised that feedback was provided both verbally and through food forums to the chef, however consumers were not satisfied with the resolution of their feedback. Two representatives said they were reluctant to complain to management for fear of repercussion for their family member in the service. The Assessment Team observed locked feedback boxes and feedback forms located in communal areas of the services for internal feedback however no external complaints brochures were observed. Management acknowledged that the service was not providing sufficient information regarding feedback and complaints in English or other languages and arranged for this to occur during the Site Audit.

Consumers and representatives consistently said the service does not provide appropriate actions to resolve complaints. Consumers said they are usually able to talk to staff or management to address simple issues, however, most consumers interviewed were not satisfied the service and management had demonstrated actions to improve services, for example regarding the impact on consumers of other consumers wandering behaviours, care and meal services, which consumers and representatives said has been an ongoing issue. Several representatives have complained about staff at the service not answering their calls or taking a long time to respond and often they are not satisfied with the outcomes. A number of representatives all complained with regard to poor communication with the service, phone calls not being answered and no follow up with their concerns.

The complaints register reviewed reflected systemic negative feedback and complaints in relation to food that have been ongoing over a twelve-month period. Management explained that when complaints were received from consumers and representatives, the first approach was to speak with the consumer and representative including the chef and address their concerns in the resolution process to rectify the issues. Despite this occurring there are still ongoing issues that are yet to be resolved.

The complaints register identified feedback and complaints received, date raised, issues identified, planned actions results and date of completion. However, details with regard to action taken were not identified as having been completed even though ‘date completed’ was noted and there was no documentation to indicate that strategies taken had resolved the issue. The Assessment Team confirmed the register also reflects in some instances ‘open disclosure’ processes have been applied. However not all feedback and complaints identified by the Assessment Team were recorded in the complaints register. Management acknowledged lack of analysis and monitoring or evaluation of complaints.

Management could not demonstrate it has processes in place to review feedback and complaints and how the review information is used to continuously improve the quality of care and services for consumers. Most consumers and representatives said they were not aware of any significant improvements to care and meals services following their submission of complaints and feedback. Several consumers and representatives complained that the service was not managing consumers with wandering behaviours, and this was an ongoing issue. This has not been addressed in the service’s Continuous Improvement Plan.

Overall consumers said we still have ongoing issues with meals arriving cold, and poor quality of the food had caused some consumers to have no interest in eating, some saying they just go without. Most consumers interviewed said the quality of meals served had not improved confirming the issue of the ‘cold’ meals is on ongoing problem, even after providing continuous feedback to management and at the food forum meetings and other mechanisms.

The Assessment Team reviewed the complaints register with the Continuous Improvement Plan which was found to be inconsistent and identified gaps where no action, no evaluation or completion dates were determined.

The approved provider responded to the Assessment Team’s report and provided a copy of the Continuous Improvement Plan and Training Plan. The provider advised that management would report regularly to the Board about feedback and complaints and communication in relation to complaints mechanisms will be provided to consumers and representatives. The policy and procedure for managing feedback will be reviewed and updated with process guidance developed to align with the policy.

I acknowledge the providers response and planned actions, however, understand that it will take some time to effectively implement these actions to reflect compliance.

I find that the approved provider is non-compliant with these requirements.

The following requirement was found to be compliant:

* Requirement 6(3)(b)

The Assessment Team found that most consumers and their representatives said they were aware of advocacy services to support them to make complaints. Some consumers said they would rely on their representatives to make complaints on their behalf. The service provides information on advocacy services, external complaint organisations through the welcome admission information pack, and the consumer handbook. However, there were no brochures or posters on display easily accessible to consumers and representatives.

Care staff described how they encourage and assist consumers to complete feedback forms or had provided forms for their families to complete. Another staff member said there is a consumer who is an advocate and voice for other consumers, taking their suggestions and feedback to the committee meetings. Staff indicated, if needed, they could request assistance with advocacy for consumers and could also engage the social worker, or pastoral care workers if preferable.

Management explained that feedback and advocacy is discussed at consumer meetings to encourage feedback on care and services. The process of how and who to provide feedback to is also provided at meetings, including external advocacy services such as OPAN, Seniors Rights Service or the Commission. However, this was not reflected in the meeting minutes reviewed by the Assessment Team.

**Standard 7**

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

**Findings**

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

The following four requirements were found to be non-compliant:

* Requirement 7(3)(a)
* Requirement 7(3)(c)
* Requirement 7(3)(d)
* Requirement 7(3)(e)

The Assessment Team identified that the organisation does not have sufficient staff at the service to ensure the delivery and management of safe quality care and services. The facility manager advised that there has been a high turnover of staff and all staff are new to the service. Records indicate that 96% of staff have commenced since January 2022 including management and clinical staff. Consumers and representatives have commented that there is a shortage of staff at the service, and this was impacting on consumers care and safety.

Some staff commented that they are very busy and are sometimes short staffed. One staff said they could do with at least one more staff in the morning and afternoon shifts particularly as more consumers are requiring two-person assistance to transfer and some consumers had wandering behaviours. They said they sometimes work back to finish writing their notes after their shift and are often asked if they would like to pick up an extra shift by management. Another staff member said they must prioritise consumer’s needs, so they attend to the most urgent first.

Management advised that it has been a challenging time for them with 6 COVID-19 outbreaks in the past 2 years and a high turnover of staff. The service has reviewed its staffing policy in September 2022 resulting in only employing staff directly into the service and not using any agency staff. The facility manager said staff work a 40-hour week part time. Unfilled shifts are taken up by existing staff, doing double shifts or additional hours. If a registered nurse shift is unfilled this is taken up by the facility manager or acting facility manager who are both registered nurses. The facility manager confirmed that this would mean both managers taking on a dual role at times. She reported however that there were no unfilled shifts on the roster, but agency staff would be considered during an outbreak. The Assessment Team observed a leisure and lifestyle staff gathering a group of consumers for an activity, who had to leave the activity on several occasions to attend to other consumers who were wandering the corridor or calling out.

The Assessment Team identified that staff do not always have the skills and knowledge to effectively perform their roles. New staff commencing at the service have little orientation into their roles. Several consumers and representatives have complained or commented on the lack of knowledge regarding staff at the service.

The executive team advised that most staff are new to the service and are being provided with orientation and buddy shifts to orientate them into their roles. They advised that ongoing training is being provided to all new staff on a rolling basis by the education manager and clinical competencies are completed by the facility manager or the assistant facility manager and some competencies are completed during buddy shifts.

Orientation records were requested but not provided. Staff advised that orientation provided included familiarisation with the facility generally. No other training is provided during orientation. The executive team advised that new staff were required to undertake training in the organisation’s electronic consumer record system, however, to date only 32 staff have completed this. The facility manager said that a laminated information sheet to guide staff in the use of the system was in the nurses’ station. However not all staff were aware of this, and one staff said they would ring the registered nurse if they needed assistance to find consumer information in the system. Management acknowledged that the electronic consumer record system was not always easy for staff to navigate, and some staff were not computer literate.

Staff at the service are not effectively trained or supported by the organisation to deliver quality care and services to consumers. Staff training records indicate that most staff have not been provided with sufficient education including mandatory training to effectively perform their roles.

Management advised that staff training is provided mostly online, and some training is provided face to face during buddy shifts and toolbox talks. They said training is ongoing and provided a schedule of upcoming training and training completed by staff. However, not all training records or staff attendance records reviewed were complete, with several undated training records for face-to-face training. It was also identified that a falls prevention and management policy used as an education resource was dated 2013 and there was no antimicrobial stewardship training evident. Several staff did not recall having completed training in SIRS, open disclosure or antimicrobial stewardship and were unable to describe its relevance to them.

Staff are not always supported in their roles for example one staff member said the registered nurse informs them of any changes to consumer however said, ‘it would be good if we could see the care plan’.

The service does not have an effective system and processes to monitor and review the performance of each member of the workforce. The facility manager said that all staff are new and staff appraisals are yet to commence for staff. However, there was no evidence that staff appraisals had been scheduled after staff probationary period or on an ongoing basis.

Incident record documentation reviewed indicated that staff have been provided with additional training or review following specific incidents, however these were not evidenced by the Assessment Team. The facility manager advised that there have not been any staff identified as requiring performance management since her commencement in August 2022 but was not able to provide any previous staff performance records.

The approved provider responded to the Assessment Team’s report and provided a Continuous Improvement Plan and Training Plan. The provider advised that the education schedule will be reviewed and redeveloped to provide training in the areas of non-compliance and will monitor the completion of training for staff. The Continuous Improvement Plan will include information in relation to performance reviews and gaps in staff practice.

I acknowledge the approved provider’s response, however, understand that this will take some time to reflect compliance.

I find that the approved provider is non-compliant with these requirements.

The following requirement was found to be compliant:

* Requirement 7(3)(b)

The Assessment Team found that overall consumers and representatives said staff were kind, caring and respectful of consumers. Representatives provided feedback that the staff are lovely but there is a high turnover of staff and extra staff are required.

**Standard 8**

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

**Findings**

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

The organisation is unable to demonstrate that it actively engages and supports consumers in the development, delivery and evaluation of care and services. Consumers are not encouraged to participate in their day-to-day care and do not have a broader representation in the planning of their care and services. Management do not have a good understanding of consumer engagement as required by this Standard. Deficiencies across the Standards identifies consumers are not engaged in the overall planning and development of their care and services.

Not all consumers and representatives are made aware of resident meetings or provided with meeting minutes. Feedback and complaints from consumers and representatives are encouraged by the service. However effective actions are not always taken in response to complaints and the service has not been providing easy access to external complaints or advocacy services to assist consumers to provide feedback. The organisation was unable to demonstrate that it has developed diversity plans for the service. During the Site Audit management provided two draft fact sheets on LGBTI and Closing the Gap information. The service was unable to provide additional information where it has sought feedback from consumers such as consumer surveys.

The organisation’s governing body is not provided with sufficient information and in a format for them to be effectively involved in or be accountable for the planning, delivery and evaluation of care and services. Whilst operational risk reports are provided to the governing body, it has been unable to demonstrate that the organisation has overall strategic plans in place to manage risks. Deficiencies identified across the Quality Standards indicate the organisation has not been effective in providing safe and quality care.

The Assessment Team asked how the organisation ensures it is meeting the Quality Standards, the director advised it relies on clinical indicator reports prepared by the management team on site. The director stated that the organisation has implemented a clinical governance form in August 2022 with clinical leads. The forum provides education and information to clinical leaders such as changes in legislation. However, they do not provide advice and analysis of clinical outcomes to the board.

Summary findings to the board for July has a goal to reduce falls and injuries across all sites. With mitigation strategies to be “fleshed out” of clinical government forum to be held on 31 July 2022, however no action plans have been provided. The director advised that decisions from the board are not recorded as minutes or formalised and are usually provided to management via emails. The Assessment Team identified information provided to the board in summary clinical indicator reports is not always consistent or accurate.

The director advised that the organisation’s strategic plan is in development and the board wanted to wait for a consumer forum to determine the direction of the plan. No further information was provided to indicate how strategic risk is being monitored or managed by the board.

The organisation’s governance systems are ineffective regarding information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

The organisation’s systems for information management does not provide sufficient, consistent or readily available information for staff and management to perform their roles effectively. The service’s electronic consumer record system has been difficult for staff to understand and navigate. Several staff have stated that staff put information into different places and is sometimes not easily located. The facility manager said that a laminated instruction sheet for staff to follow is in the nurse’s station. One staff member who was asked by the Assessment Team for a behaviour chart for a consumer did not know where to find this on the consumer record system and had to ring the registered nurse to locate it. Clinical documentation is inconsistent with gaps in risk assessments when incidents occur.

The organisation does not have effective continuous improvement systems in place. The organisations systems to collect and review the feedback of consumers and their experience is not routinely included as part of the quality improvement system. Continuous Improvement Plans are undertaken at service level and a combined organisation level. The services Continuous Improvement Plan does not always reflect information identified in feedback, complaints, or incidents for the period. There are no identified analysis or evaluation of actions taken to identify if strategies and actions are effective, for example a falls prevention strategy raised on 20 September 2022 has a completion date of 28 October 2022 however no evaluation has been recorded. Significant incidents such as challenging behaviours do not have any continuous improvement strategies in place despite continued reoccurrences.

The organisation has had a significant turnover of staff over the past year, and this is impacting on overall staff skill and knowledge. Many staff have not had adequate orientation or education regarding the Standards. There has also been a high turnover in management and clinical staff with most having been engaged in the past two months.

The organisation is not able to demonstrate that it has sufficient staff to provide safe and quality care to consumers with several consumers and representatives complaining of the service being short staffed. Staff have commented that they are busy with the increasing care needs of consumers at the service.

The organisation does not have an effective incident management system to mitigate significant incidents at the service. Deficiencies have been identified in the effectiveness of intervention strategies as they have not been analysed or evaluated. A review of care documentation for consumers experiencing high falls or challenging behaviours identifies the service is not managing consumers appropriately and legislative requirements in relation to incident management and SIRs reporting have not been followed or reported.

The organisation does not have an effective risk management system and practices are not in place at the service relating to managing risks to the health, safety and well-being of consumers. Identified risks are not being effectively evaluated to reduce or remove the risks that match the level of risk and how it is affecting consumers. Deficits in the individual consumers’ care and assessment documentation has been identified when reviewing consumers with high impact or high prevalence risks, including managing challenging behaviours.

The organisation’s policies and procedures were reviewed in relation to antimicrobial stewardship, the use of restraint and open disclosure. The organisation has an overarching clinical governance framework however does not include key elements of clinical governance. Deficits were identified in Standards 3, 5, and 6 regarding antimicrobial stewardship, minimising the use of restraint and open disclosure. Management acknowledges there were gaps in these areas and said that staff were new to the service and training was still ongoing to ensure that they had the knowledge and skills in these areas.

The service is not practicing efficient transmission-based precautions to prevent and control infections. Whilst the service was able to demonstrate appropriate antibiotic prescribing practices were in place, observations of infection control practices identified several instances where the was not being practices such as with clinical and other waste, and personal hygiene practices.

The service environment is not providing a safe environment which enables consumers to move freely, both indoors and outdoors such as restricting consumer access to around the service via the lift and to the outdoor area on the ground floor. The Assessment Team identified a lack of clinical governance when reviewing consumers with high impact or high prevalence risk regarding clinical and operational information provided to the board by the service for the board to make decisions regarding understanding risks to consumers.

Training records were not evidenced to indicate that staff have been provided with training, toolbox talks are planned for restrictive practices and open disclosure in November 2022 but have not yet been completed.

The approved provider responded to the Assessment Team’s report and provided a copy of their Continuous Improvement Plan and Training Plan. The provider refuted the Assessment Team’s report in relation to this Standard, however there was no evidence provided to support that feedback from consumers resulted in changes or improvements to the delivery of care and services or that all consumers are supported to be engaged or made aware of resident meetings or provided with meeting minutes. The provider did not feel that organisationally this reflected the Hardi Aged Care Facilities, as the remaining services had received 3-year accreditation, however the organisation could not demonstrate that their governance systems, risk management systems or clinical governance framework are effective at this service. The provider advised that there will be a full review of policies, procedures and related flowcharts. A suite of policies and procedure will be mapped to the Standards. The clinical framework will be reviewed to further highlight areas of antimicrobial stewardship, restrictive practices and open disclosure.

I acknowledge the provider’s response; however, the provider does not demonstrate effective governance for Wyoming Nursing Home against this Quality Standard and the associated requirements.

I find that the approved provider is non-compliant with this requirement.

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