GLENVIEW
Community Services

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Enforceable Undertaking

Aged Care Quality and Safety Commission Act 2018
Section 74EC
Regulatory Powers (Standard Provisions) Act 2014
Section 114

The commitments in this undertaking are offered to the Aged Care Quality and Safety Commissioner by:

GLENVIEW COMMUNITY SERVICES INC
ABN 57 626 897 081
RACS 8060 & 8083
2-10 Windsor Street, Glenorchy, TAS, 7010

1 DEFINITIONS

Acceptance Date means the date of acceptance by the Commissioner of this Undertaking.

Aged Care Act means the *Aged Care Act 1997*.

Approved Provider means a person approved by the Commissioner under section 63 of the Commission Act as a provider of aged care.

Commission Act means the *Aged Care Quality and Safety Commission Act 2018*.

Commission Rules means the *Aged Care Quality and Safety Commission Rules 2018*.

Commission means the Aged Care Quality and Safety Commission established by section 11 of the Commission Act.

Commissioner means the Commissioner of the Commission, or a person delegated under section 76 of the Commission Act to perform the Commissioner's functions or exercise the Commissioner's powers.

Continence Advisor means a Registered Nurse who is a specialist in the management of continence care.

Glenview Community Services Inc. means the residential care service located at 2-10 Windsor Street, Glenorchy, Tasmania, 7010.

Korongee means the residential care service located at 264A Main Road Glenorchy, Tasmania, 7010.

Provider means Glenview Community Services Inc (ABN 57 626 897 081), in its capacity as an Approved Provider.

Quality Principles means the *Quality of Care Principles 2014*.

Quality Standards means the Aged Care Quality Standards contained in Schedule 2 of the *Quality of Care Principles 2014*.

Regulatory Powers Act means the *Regulatory Powers (Standard Provisions Act) 2014*.

Service(s) means the residential care services through which the Provider provides residential care at Korongee and Glenview Community Services Inc.

Undertaking means this Enforceable Undertaking.

2 INFORMATION

Commissioner's role

The Commissioner has responsibility for the regulatory functions under the Commission Act including the power to accept an enforceable undertaking in accordance with section 114 of the Regulatory Powers Act.

Purpose

The purpose of this Undertaking is to state the undertakings voluntarily offered to and accepted by the Commissioner under section 74EC of the Commission Act and section 114 of the Regulatory Powers Act in relation to the non-compliance described in Part 3 of this Undertaking and the Provider's commitment to address the matters set out in Part 4.

Commencement

This Undertaking commences on the date that the Commissioner signs the Undertaking. Upon the Undertaking taking effect, the Undertaking becomes enforceable under section 115 of the Regulatory Powers Act.

Term of the Enforceable Undertaking

This Undertaking continues, as varied from time to time, from the commencement date until it is withdrawn by the Provider with the Commissioner's consent under section 114 of the Regulatory Powers Act or cancelled by the Commissioner under section 114 of the Regulatory Powers Act, whichever is earlier.

3 PROVIDER PERFORMANCE

Services

The Provider operates the Services and employs 334 staff including 25 key personnel across the two residential aged care services:

- Korongee is purpose-designed to provide care for people with dementia in a perimeter-secure environment. Korongee can accommodate up to 96 residents in 12 small households of 8 people. Korongee currently accommodates 90 residents.

- Glenview Community Services Inc. is a residential aged care home that provides care for up to 99 residents, including a maximum of 9 residents in a secure Specialist Dementia Care Program unit and currently accommodates 96 residents.

Identified Areas for Improvement

Korongee Performance Report

The Performance Report for Korongee from the site audit conducted on 4 to 6 March 2024 identified non-compliance with three requirements of the Quality Standards: 3(3)(a), 7(3)(a) and 8(3)(c). The Commissioner made a decision on 21 April 2024 to re-accredit this service for the period expiring on 26 May 2027. It has a current 4-star rating. In September 2024, the most recent month for which data is available, Korongee provided an average of 212 direct care minutes per consumer per day against a target of 193 minutes per day and is fully compliant with its obligation to ensure at least one Registered Nurse is onsite and on duty at all times.

The Commissioner has noted the following findings of concern from the Performance Report to the Provider:

- Environmental restrictive practices evident from the locking mechanism on the front door which prevents consumers who do not have swipe cards from leaving to exit.
- Continence and hygiene have been compromised by delays in addressing incontinence and trying alternative aids, which has led to increased aggressive responses due to insufficient support.
- Staff struggled to support consumers with changing behaviours.
- Ongoing issues with managing changed consumer behaviours, staffing levels, and high turnover.
- Number and sufficiency of staff to provide safe and effective care.

The Commissioner has also informed the Provider of concerns about Quality Standard 1(1)(a), in addition to 3(3)(a), about continence and hygiene arising from the number of complaints the Commission has received pertaining to residents being left in soiled incontinence aids for an extended period of time.

Glenview Community Services Inc. Performance Report

The Performance Report for Glenview Community Services Inc. from the site audit conducted on 4 to 6 June 2024 identified non-compliance with two requirements of the Quality Standards: 3(3)(b) and 8(3)(e). The Commissioner made a decision on 12 July 2024 to re-accredit this service for the period expiring on 25 August 2027. In September 2024, the most recent month for which data is available, Glenview Community Services Inc. provided an average of 240 direct care minutes per consumer per day against a target of 197 minutes per day and fully compliant with its obligation to ensure at least one Registered Nurse is onsite and on duty at all times. It has a current 4-star rating.

The Commissioner has noted the following findings of concern to the Provider:

- The service did not demonstrate appropriate identification, monitoring, and minimisation of the use of restrictive practices.
- Behaviour support plans were not individualised and did not detail non-pharmacological strategies to be utilised prior to the use of a restrictive practice or that restrictive practices should be used as a last resort.

- The reports to the board and clinical governance committee did not include relevant metrics in relation to restrictive practices.

Quality Principles

The Commissioner is concerned that the Provider is non-compliant with Part 4A and Part 4B of the Quality Principles.

Behaviour support and restrictive practices

The Commissioner identified seven areas of concern with respect to behaviour support and restrictive practices (sections 15FA, 15FB, 15FC, 15GA, 15HB, 15HE & 15HF, Quality Principles) in relation to two residents. The Commissioner is concerned that the behaviour support plans did not show sufficient information about: using the restrictive practices as a last resort; considering or using best practice alternative strategies; assessment of use; informed consent; ongoing use of restrictive practices including monitoring, review and consultation; and engagement with external support services.

Incident management and prevention

The Commissioner has identified four areas of concern with respect to incident management and prevention (sections 15LA, 15LB, 15MC and 15MD, Quality Principles) arising from an analysis of the Serious Incident Response Scheme notifications and falls data. The Commissioner is concerned that:

3.1 The notifications showed higher than expected reporting in some areas (e.g. unreasonable use of force and unlawful or inappropriate sexual contact) and lower than expected reporting in other areas (e.g. neglect, abuse, unexplained absence, stealing or financial coercion, unexpected death, inappropriate use of restrictive practices).

3.2 The falls data showed a high ongoing incidence of falls and consequent immobility.

- The recurrence of reportable incidents indicating a failure in the review and analysis of trends to assist with risk prevention and strategies.

Engagement with the Commission

As a result of the Korongee Performance Report and the complaints regarding care at Korongee and Glenview Community Services Inc., the Commission's Compliance Management Group has been engaged with the Provider since May 2024 in response to the Commissioner's concerns about the risks posed to residents. The Compliance Management Group has:

- Shared its concerns regarding the Provider's approach to managing and reporting residents changed and complex behaviours.

- Provided support and guidance to address the concerns, including consultation with the Commission's Behaviour Support and Restrictive Practices Unit.

- Outlined the Commission's Provider Supervision model and approach to working with approved providers where there is identified risk and non-compliance, including escalating regulatory pathways, if there is continued non-compliance and changes were not implemented in a reasonable timeframe.

The Provider's Acknowledgments

The Provider admits the non-compliance identified in the Performance Reports and acknowledges the Commissioner's concern that the Provider is non-compliant with Parts 4A and 4B of the Quality Principles.

4 PROVIDER UNDERTAKINGS

In accordance with the operation of section 114 of the Regulatory Powers Act and section 74EC of the Commission Act, the Provider has offered and the Commissioner has accepted the following undertakings:

Korongee

1. The Provider will implement and monitor best practice continence care for people living with dementia that will include the following actions:

    a. Staff will be provided with face-to-face education regarding best practice continence care and the education will include strategies to support continence care for people living with dementia. The Provider will provide up to (but not limited to) four face-to-face sessions per month with staff to attend one session per month. The training plan will be used to schedule the sessions, and feedback will be gained from participants regarding the content and learnings. The training plan will commence by **31 January 2025**.

    b. The Services will undertake a review of incontinence aids, the storage and supply to ensure that the service meets the individual needs of the residents. This will be completed by **31 January 2025**.

    c. We will take active steps to engage a Continence Advisor to ensure residents living with incontinence have access to specialist services and staff are educated about best practice continence management by **28 February 2025**.

    d. The Provider will ensure there is 100% completion by all care and clinical staff of continence management training via the AusMed Learning Management System and/or an alternative resource and ensure education on continence management is included as part of the onboarding process for all care and clinical staff across the Services by **28 February 2025**.

    e. The Provider will monitor and report monthly on incontinence associated dermatitis (IAD) to ensure the continence care is meeting best practice and incontinence is managed in a timely manner for people living with dementia. This will be commenced via the Monthly Clinical Incident and Analysis reporting by 31 **January 2025**.

2. The Provider will have the following evidence to support implementation of the agreed undertakings:

a. Have a clinical and care workforce that can provide continence care to people living with dementia. This will be demonstrated through:

   i. Participant feedback from education sessions.

   ii. Continence care plans including an assessment for residents living with dementia that outlines how the workforce supports each individual resident with their continence care.

   iii. Feedback and complaints will be reviewed each month and identify continence and / or the management of incontinence (if there is related feedback) to inform ongoing practice improvements.

   iv. Incontinence Associated Dermatitis (IAD) will be identified and managed using best practice principles. IAD data will be reviewed monthly as part of management reporting responsibilities.

   v. Continence management system including ordering, storage and distribution of continence aids will be reviewed and recommendations updated to ensure that residents changing continence needs are met.

b. The Provider will evaluate the effectiveness of the actions taken to implement best practice continence care for people living with dementia by 31 **May 2025**.

3. In respect of Korongee's non-compliance with Quality Standard 7(3)(a) the Provider will:

   a. Develop and embed a Workforce Logistics Group by 28 **February 2025** to review key metrics which include (but not limited to): personal leave trending; agency staffing levels and trending; performance management compliance; and training compliance. It will include monthly monitoring and reporting to the Board.

   b. Evaluate the performance of the Workforce Logistics Group by 31 **May 2025** via reporting and trending which will include a staff survey and analysis to validate improved levels of personal leave trending, agency staffing levels, reduced levels of unfilled shifts and high levels of training compliance.

4. In respect of Korongee's non-compliance with Quality Standard 8(3)(c) the Provider will:

   a. Develop a Quality, Safety and Clinical Risk Framework by **28 February 2025** that sets strategy and provides guidance for the gathering, analysis, actioning and monitoring of quality data for the safe delivery of care and services at the Services.

   b. Implement the Quality, Safety and Clinical Risk Framework and include the following key deliverables:

i. Develop a monthly clinical incident and analysis report for the Services to ensure there is monthly review of clinical incidents that will include (but is not limited to) falls, unplanned weight loss, pressure injuries, skin integrity incidents (including IAD), medication related incidents, and behaviour incidents. The monthly clinical incident and analysis report will identify any commons trends or themes in relation to the clinical incidents and will outline key actions to be taken the following month to reduce the occurrence and/or the level of impact and harm caused to residents from clinical incidents. The report will be developed by **January 2025** and will be in place from **February 2025** onwards.

ii. The Executive Manager Clinical Governance (EMCG) will develop a monthly report that will go to Clinical Governance Committee and the Provider's governing body about the key clinical areas of risk, opportunities for improvement and recommended actions and this information will be gathered from the monthly clinical incident and analysis reports from the Services. This report will be developed by **January 2025** and will be in place every month from **February 2025** onwards every month.

iii. The Provider will use the quarterly quality indicator data to inform ongoing continuous improvement. The Provider will provide the Clinical Governance Committee and the Board quarterly reports from **November 2024** that outline clinical indicator analysis for the Services and include trending against state and national data.

c. The Provider will have the following evidence that will support its implementation:

i. Have evidence of monthly clinical incident and analysis reports for the Services,

ii. Have evidence of a monthly report from the Executive Manager Clinical Governance that outlines key themes and trends from monthly clinical incidents and actions that teams are taking to ensure a continuous cycle of improvement,

iii. Have evidence of quarterly reports that outline key trends of clinical indicators and actions will be documented and outlined in the (i) the report and (ii) on the continuous improvement plan for the Services.

iv. The organisational Continuous Improvement Plan will provide additional evidence of any actions and ongoing improvements that are identified during monthly and quarterly incident analysis.

d. The provider will ensure the above actions and associated evidence are all completed by April 2025 and will be ongoing thereafter that date.

e. The Provider will evaluate the effectiveness of the Quality, Safety and Clinical Risk Framework by **31 May 2025**.

f. The provider will ensure Korongee is compliant with the Quality Standards 1(1)(a), 3(3)(a), 7(3)(a) and 8(3)(c) by **31 May 2025**.

Glenview Community Services Inc.

5. In respect of Glenview Community Services Inc's non-compliances with Quality Standards 3(3)(b) and 8(3)(e) the Provider will:

    a. Develop a High-Risk Resident Framework by **31 March 2025** and the implementation of this will include the following deliverables:

        i. A High-Risk Resident Register (**HRRR**) and associated operational meetings to guide weekly oversight of residents identified as high risk to guide clinical review, timely assessment and follow up with multidisciplinary team members by **February 2025**.

        ii. The HRRR will provide evidence of critical incident investigations including their outcome and changes to practice.

        iii. The HRRR and associated reviews will ensure there is a framework for clinical teams to ensure effective antimicrobial stewardship, minimising the use of restraint and open disclosure principles.

    b. Embed the High-Risk Resident Framework and monitor the implementation of the framework by **30 April 2025**.

    c. Ensure Glenview Community Services Inc. is compliant with the Quality Standards 3(3)(b) and 8(3)(e) by **31 May 2025**.

Behaviour support and restrictive practices

6. In respect of compliance with sections 15FA, 15FB, 15FC, 15GA, 15HB, 15HE & 15HF of the Quality Principles 2014 (behaviour support and restrictive practices) the Provider will:

    a. Review each resident's Behaviour Support Plans (BSP) to ensure that:

        i. Each resident's BSP is individualised and outlines the individual behaviour management strategies for each resident and clearly outlines strategies for staff to follow and support residents living with dementia and will be reviewed when needs change for the resident or accordingly to the organisational policy in line with the Quality Principles (sections 15HB 15HE, and 15HF).

ii. There is evidence of consultation with families or representatives to support the development of the individualised BSP's including gaining valid informed consent to the use of restrictive practices, which are to be used only as a last resort to prevent harm to the resident or other persons, and after consideration of the likely impact of the use of the restrictive practice on the care recipient in accordance with section 15FA Quality Principles.

b. Review the current organisational policy and procedure on Behaviour Support Planning and the linkage it has to minimising the use of restrictive practices including the process of gaining valid informed consent, the additional requirements for the use of restrictive practices other than chemical restraint and an outline of the responsibilities while restrictive practices are being used in accordance with sections 15FB, 15FC, and 15GA Quality Principles.

c. The Restrictive Practice Register and Psychotropic Register will be monitored to ensure that legislative requirements are being met. The EMCG will provide the Clinical Governance Committee with updates on the Restrictive Practice Register at Glenview Community Services Inc.

d. Ensure the Services are compliant with the Quality Principles sections 15FA, 15FB, 15FC, 15GA, 15HB, 15HE & 15HF by **31 March 2025**.

Incident management and prevention

7. In respect to compliance with sections 15LA, 15LB, 15MC and 15MD of the Quality Principles (incident management and prevention) the Provider will:

    a. Develop and implement a Safety, Quality and Clinical Risk Framework by **31 March 2025** that will outline the key actions required for effective incident management and includes:

        i. Develop consistent clinical operational reporting each month for each Service and will include but is not limited to:

            a. Clinical Incidents: falls, injury with falls, behaviour, pressure injury, weight loss, wounds, continence and SIRS.

            b. Medication related incidents.

            c. Infection control and antimicrobial stewardship.

        ii. Use of Psychotropic agents and restrictive practice. Develop a High-Risk Resident Framework and meetings as outlined in Undertaking 5.

        iii. The EMCG develop a high-level overview of the key clinical risks and areas of concern and opportunity based on monthly reporting and provide this to the Clinical Governance Committee.

        iv. Benchmark quarter quality indicators to understand key areas of concern and identify opportunities for improvement.

b. Embed the Safety, Quality and Clinical Risk Framework and monitor the implementation of the framework by **30 April 2025**.

c. Ensure the Services are compliant with the Quality Principles sections 15LA, 15LB, 15MC and 15MD by **31 May 2025**.

8. The Provider will submit a comprehensive and detailed self-assessment of the above undertakings to the Commission **by 31 May 2025** demonstrating with clear evidence:

   a. What steps the Provider has taken to give effect to each undertaking.

   b. The impact of those steps on achieving compliance with the Quality Standards and the Quality Principles.

   c. A statement explaining how improved compliance will be sustained.

9. Milestones reporting will be delivered monthly in meetings with the Commission.

10. The Provider commits to co-operating with the Commission throughout the duration of the Undertaking.

11. The Provider undertakes that it will pay all of its costs associated with its compliance with this Undertaking.

5 ACKNOWLEDGMENTS

The Provider acknowledges that the Commissioner:

a. Will publish this Undertaking on the Commission's website.

b. May make public reference, including by way of media release and/or Commission publications of acceptance of this Undertaking referring to its terms and to the concerns of the Commissioner which led to its acceptance, however the terms of any media release must be consistent with this Undertaking.

The Provider acknowledges that:

a. This Undertaking has no operative force until accepted by the Commissioner.

b. The date of the Undertaking is the date on which it is accepted by the Commissioner.

c. The Undertaking is given voluntarily by the Provider, who has obtained legal advice in relation to its obligations under, and the effect of, this Undertaking.

d. The Commissioner's acceptance of this Undertaking does not affect any rights, remedies and powers available to the Commission, or the Commonwealth.

e. The Commission may undertake compliance monitoring activities to verify the evidence submitted as required by Part 4 and the Provider's compliance with the Undertaking.

f. The Commissioner has the power to enforce the Undertaking under section 115 of the Regulatory Powers Act and may exercise this power if any requirement or condition of the Undertaking is breached.

g. If any part of this Undertaking is held invalid that part shall be severed from this Undertaking and the remainder of this Undertaking will continue to be valid and enforceable.

h. The references to provisions of Commonwealth Acts of Parliament and Legislative Instruments in this Undertaking shall include references to those provisions as amended from time to time and in the event of a repeal of any of them, any equivalent provision from time to time.

The provider confirms it has the operational and financial capacity to comply with the Undertaking.

6 PROVISION OF DOCUMENTS

The address for providing the Commission with any notice or document which this Undertaking requires to be provided is: Aged Care Quality and Safety Commission GPO Box 9819 CANBERRA ACT 2601 Attention: Executive Director, Peter Edwards

Executed by Glenview Community Services Inc

ABN 57 626 897 081 in accordance with its constitution

Signature of president

Signature of secretary

CRAIG ANDRIKONIS

Name of president
(please print)

Damien Jacobs

Name of secretary
(please print)

Date accepted by the Commissioner:

ACCEPTED by the **AGED CARE QUALITY AND SAFETY COMMISSIONER** under section 74EC of the Commission Act and Section 114 of the Regulatory Powers Act

J. M Anderson

Aged Care Quality & Safety Commissioner

Witness

Olga Popovic

Witness full name *(please print)*