Kubirri Aged Care Centre

Performance Report

49 Johnston Road
MOSSMAN QLD 4873
Phone number: 07 4084 4900

**Commission ID:** 5783

**Provider name:** The Salvation Army (Queensland) Property Trust

**Site Audit date:** 20 April 2021 to 22 April 2021

**Date of Performance Report:** 24 June 2021

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Site Audit report received 27 May 2021.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Consumers considered that they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they chose. Consumers stated that staff knew them and what was important to them, and most consumers advised their personal privacy was respected. Consumers/representatives advised they received information important to them.

Staff consistently spoke about consumers in a way that demonstrated respect and an understanding of their personal circumstances and life journey. Staff were aware of consumer’s cultural backgrounds, what was important to them and how the care they delivered was adapted for individual consumers to ensure the consumer felt valued and safe.

Consumer care planning documents reflected what was important to them and identified their cultural needs. Documentation identified consumer’s preferences and people that mattered to them. The organisation’s Diversity and Inclusion Policy identified the service ‘embraces diversity and seeks to foster a culture of inclusion’; the organisation’s Privacy Notice was displayed in the reception area of the service.

However, the service was unable to demonstrate that consumers were safely supported to take risks that enabled them to live the best life they could; risk assessments had not been consistently completed for consumers who chose to take risks. While consumers were able to undertake activities they wished to pursue, the service did not demonstrate that effective risk management strategies were in place to support these consumers and that adequate action had been taken to educate, advise and manage risks regarding activities such as leaving the service unattended and smoking.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

### Requirement 1(3)(d) Non-compliant

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

Management identified the service had several consumers that took risks, including one consumer who left the service without appropriate notification and three consumers who were smokers. However, the service was not able to demonstrate how each consumer was supported to take risks through the completion of risk assessments individualised for each consumer, the implementation of strategies to mitigate or manage the risks, and that discussion of the risks and management strategies with the consumer and/or their representative occurred.

One named consumer with complex medical and cognitive care needs that required regular administration of medication and support from staff, would leave the facility to go into the community and stay out overnight; during this time the consumer’s whereabouts and personal safety was unknown by the service and/or the consumer would on occasion return to the service in an intoxicated state. While a risk assessment in relation to the consumer’s absences was initiated on 4 February 2021, it was identified there was no documented evidence a discussion in relation to these risks had occurred, the risk assessment did not capture all relevant risks relating to the consumer leaving the service unsupervised and how these risks could be mitigated.

The Approved Provider in its written response to the Assessment Team’s findings, and through their provision of the service’s plan for continuous improvement, stated a ‘customer risk safety assessment’ in relation to the consumer leaving the service had now been completed on 24 May 2021, which reflected strategies and care directives to manage the identified risks, and a case conference was held to discuss these risks and strategies that included alternate activities/options for the consumer’s pastimes. A further assessment is being conducted by the service to determine possible support to be provided through the National Disability Insurance Scheme. The Approved Provider is further liaising with the organisation’s technology solutions team to identify best options for the consumer’s safety, location and way finding between the community and the service. Community support is being accessed in relation to outings for the consumer and to minimise risk. The service has reissued a dignity of risk brochure to all staff to read in April 2021.

While reviewed care documentation identified risk assessments had been initiated to ascertain the safety to smoke for three named consumers diagnosed as cognitively impaired, the assessments had not been completed by staff. The Approved Provider provided evidence to reflect that during the site audit these risk assessments were completed (21 April 2021).

I acknowledge the Approved Provider’s response to the findings at the site audit and the actions they have taken and are planning on taking to address the deficiencies identified. However, in reviewing the information contained above it is my decision that at the time of the site audit, each consumer was not being supported to take risks to enable them to live the best life they could. Therefore, it is my decision this Requirement is Non-compliant.

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Consumers considered they felt like partners in the ongoing assessment and planning of their care and services. Consumers/representatives provided positive feedback about how the service worked in partnership with them and expressed satisfaction with the information that was provided to them about care planning processes.

Care planning documents reflected consumers/representatives were involved in assessment and planning, which included other providers of care and services such as medical officers and allied health professionals. Documentation included advance care planning and end of life planning, where consumers wished this to occur.

Staff described what was important to consumers in terms of how their personal and clinical care was delivered, including their needs, goals and preferences. Policies and procedures in relation to end of life care and planning were available to staff. Care staff advised consumers’ care plans were available to them via the electronic care management system and in hardcopy form in each area of the service.

However, while the service had processes to direct assessment and care planning, the service could not demonstrate that assessment and care planning included all risks to the consumer’s health and wellbeing, which consistently informed the delivery of safe and effective care and services and in a timely manner. While care plans were generally reviewed, this was not always done in line with the service’s procedures, and registered nurses were not completing consumers’ post fall observations in line with the services falls management protocols; however, these deficits were not identified and/or reviewed by management.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

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

While assessment and care planning processes included consideration of some risks, it did not include consideration of all risks to the consumer’s health and wellbeing. Risk assessments initiated to ascertain the safety to smoke for three named consumers diagnosed as cognitively impaired, had not been completed by staff until raised by the Assessment Team during the site audit (21 April 2021). It was further identified the updated/completed assessments did not adequately identify the risks involved for the consumer, evidence these had been discussed, and did not demonstrate adequate safety, support or management strategies had been implemented for the consumers. These consumers’ care plans did not provide direction to staff on how to maintain the safety of the consumer whilst they were smoking.

The Approved Provider in its written response to the Assessment Team’s findings reported they work with the consumer/representative to minimise risk; this process is monitored via the service’s case management tracker that evidenced consumers’ next smoking assessments were due 25 May 2022. While the Approved Provider said smoking risk assessments had been redone, the assessments provided to evidence this had completion dates the same date as risk assessments completed during the site audit (30 November 2020 and 21 April 2021). The Approved Provider advised they purchased smoking apron, fire blanket, a small extinguisher and emergency pendant. However, care plans for the three named consumers reflecting individualised management strategies to maintain their safety whilst smoking; including whether they would consent to a smoking apron or emergency pendant, were not provided.

It was identified that two named consumers who had recently entered the service did not have interim care plans completed to guide staff practice in relation to care delivery. While staff were able to describe the care needs for both consumers, newly qualified registered nurses were not aware of the service’s requirement regarding initial assessments and interim care planning processes. The Approved Provider in its written response to the Assessment Team’s findings stated that as part of the service’s new admission and assessment flowchart, all consumers are to have an interim care plan within 24 hours of entry; this is monitored via the service’s case management tracker. Registered nurses have been reminded of this requirement 17 May 2021 and assessment and care planning requirements is to be covered in the organisation’s new Graduate Program for newly qualified registered nurses, which is to be implemented by 30 June 2021.

I acknowledge the actions taken and/or planned by the Approved Provider to address the deficiencies identified in assessment and care planning. However, it is my decision that at the time of the site audit, assessment and planning, including consideration of risks to the consumer’s health and well-being, did not consistently inform the delivery of safe and effective care and services and therefore this Requirement is Non-compliant.

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

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

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

*The organisation demonstrates that assessment and planning:*

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

### Requirement 2(3)(d) Compliant

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

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

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

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 3 and Standard 8.

While care plans evidenced reviews were completed three monthly or as care needs changed, they did not consistently demonstrate the monthly ‘Resident of the Day’ review occurred in line with service’s processes; which included recording and monitoring consumers weights. It was identified for a named consumer weighs were not being recorded by care staff on the service’s electronic care management system, were not consistently being recorded on hardcopy each month (as part of Resident of the Day procedure), and registered nurses were not fully completing their consumer review tasks as part of this review process. It was identified a further five consumers had incomplete Resident of the Day reviews from March 2021, and the dietitian was unable to locate 11 consumers weighs when they visited on 22 April 2021. During the site audit, management acknowledged more education was required to ensure these monthly reviews, overseen by registered nurses, occurred.

The Approved Provider in its written response to the Assessment Team’s findings, and through their provision of the service’s plan for continuous improvement, stated the service was in the process of transitioning from their paper based system to their weight charting entered directly into the service’s electronic care management system; so that reports can be developed, and action plans initiated. Staff were reminded to transfer weights from hardcopy to the electronic care management system in April 2021 and the Approved Provider evidenced this had been completed for the named consumer. However, the Approved Provider has not specifically addressed how the service’s Resident of the Day monthly review is being monitored or reviewed, to ensure processes are being completed as required.

It was identified that post falls reviews by management had not identified that falls management protocols, relating to completion of observations for two named consumers, were not followed by staff in accordance with the service’s falls management procedure. In its written response the Approved Provider reported that registered nurses completed falls management education with a focus on neurological observations; a completion date for this education was not provided. The Approved Provider said the service’s clinical governance is under review and the revised framework will incorporate the enhancements to systems in place to measure and monitor quality and safety, as well as the best practice guidelines that are being developed.

While I acknowledge the commitment of the Approved Provider to improve the review of care and services procedures, this process was not effective at the time of the site audit and will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this Requirement is Non-Compliant.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Consumers considered that they received personal and clinical care that was safe and right for them. Consumers/representatives advised consumers received the care they needed and had access to a medical officer or other health professional when required. Consumers/representatives reported the service included them in decisions about the consumer’s care and care was tailored to the consumer’s needs, goals and preferences. Consumers nearing the end of life received safe and appropriate care which maintained their comfort and dignity.

The service had a suite of evidence-based policies reviewed at organisational level to guide staff in the delivery of care and services to consumers. Consumer’s care documentation reflected consumers were generally receiving individualised care that was safe, effective and tailored to their specific needs and preferences; this included their end of life needs and wishes.

Staff could describe consumers’ individual care needs and how these were managed in line with their care plan and described how they supported consumers who were nearing end of life to maximise their comfort and dignity. Staff provided recent examples of when a deterioration or change in the consumers’ condition was recognised and responded to.

However, the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Risks were not consistently mitigated and/or managed particularly in relation to monitoring of consumers who experience falls. While staff generally demonstrated a sound knowledge of consumers and their care needs, reviewed care documentation identified information about the consumer’s condition, needs and preferences was not consistently documented. Referrals to medical and allied health professionals, and other specialists were mostly made in a timely manner; however, this did not occur for consumers who required review by the dietitian and there was no process to ensure the dietitian was aware of consumers who required assessment.

Registered nurses did not demonstrate an understanding and knowledge to promote practices which supported the optimal use of antibiotics that reduced the risk of increased resistance to antibiotics. The service did not demonstrate that in relation to the COVID-19 pandemic they followed directives from the Queensland Health-Aged Care Directives in relation to use of personal protective equipment by visitors to the service.

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

### Assessment of Standard 3 Requirements

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

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

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

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

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

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 2 and Standard 8.

While two named consumers, who experienced falls at the service, were assessed by registered nurses and physical observations were recorded; ongoing observations that included neurological observations (where a head injury was suspected) were not completed in line with the organisation’s falls management procedures. Clinical staff had advised they were not familiar with the service’s electronic care management system and were not aware where neurological observations could be recorded for trending to occur.

The Approved Provider in its written response to the Assessment Team’s findings, and through their provision of the service’s plan for continuous improvement, reported registered nurses completed fall management education with the focus on neurological observations; a completion date for this education was not provided. The Approved Provider noted that the Care Quality and Compliance team monitors falls through their benchmarking system at a national level and compares trends against all services; each service’s individual report is reviewed with the Area Manager and actions plan implemented as required. The Approved Provider stated education on ongoing assessment and planning has been completed by registered nurses with a key focus on entering information into the electronic care system and how to practically apply this; a completion date for this education was not provided.

It was identified a named consumer receiving cytotoxic medication did not have an updated care plan to guide staff delivering care when cytotoxic precautions where required. While management said staff had received education related to required precautions necessary whilst providing care associated with cytotoxic medication, they acknowledged this information had not been documented. In their written response the Approved Provider stated cytotoxic information is entered in the complex care section of the service’s electronic care management system; evidence was provided this has been completed for the named consumer, including the requirement for staff to monitor side effects of the treatment. While the Approved Provider reported they monitor cytotoxic information in their Complex Health Care Need register, the supplied register (Appendix 12) did not reflect this for the named consumer.

The Approved Provider advised high risk, high prevalence education was provided to staff in May 2021 by an external aged care consultant, and that management of high prevalence and high impact risks is supported by a new policy and procedure authored by these consultants. This policy will be used to support the service to identify and manage high impact and high prevalence risk.

While I acknowledge the actions taken, and being taken by the Approved Provider, at the time of the site audit, high-impact or high prevalence risks for consumers were not effectively being managed. Therefore, it is my decision this requirement is Non-Compliant.

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

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

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

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

A named representative advised the service had been very responsive, attentive and was able to recognise the consumer’s recent decline. Care staff could provide recent examples of when a deterioration or change in the consumers’ condition was recognised and responded to. Staff advised they observed consumers for signs they might be unwell; this included changes in behaviour and reported these to the registered staff. Registered staff could describe the action they would take if a consumer showed signs of deterioration. Staff had access to policies and procedures and clinical information to guide them in recognising and responding to a deterioration or change in a consumer’s condition.

The Assessment Team identified that for one named consumer the service did not adequately demonstrate that deterioration or change in the consumer’s condition was responded to appropriately. It is my opinion the weight and consequence of this information, which relates more to information not being documented, is more relevant to requirement 3(3)(e).

In reviewing the information contained above I am satisfied that the service is able to demonstrate deterioration or change of a consumer’s condition is recognised and responded to in a timely manner. Therefore, it is my decision this requirement is compliant. Actions included in the Approved Provider’s written response will strengthen the sustainability of this requirement.

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

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

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 2.

While staff generally demonstrated a sound knowledge of consumers and their care needs, reviewed care documentation identified information about the consumer’s condition, needs and preferences was not consistently documented. For two named consumers who experienced changes in their condition, staff and management could describe referral to medical officer and/or transfer to hospital was undertaken, and actions taken to address and notify others of the consumer’s changed care needs. However, actions and/or follow up taken were not documented.

The Approved Provider in its written response to the Assessment Team’s findings stated registered nurses are to remind the medical officer to document all aspects of their assessment. Registered nurses are to review the medical officer’s progress notes to ensure information of assessments and actions are documented appropriately by the medical officer. Evidence was provided this was undertaken retrospectively by the medical officer for one named consumer on 24 May 2021.

It was identified that for two named consumers who had recently entered the service at the time of the site audit, interim care plans had not been completed to guide staff in the delivery of care. One of these named consumers advised the Assessment Team their personal care was not being provided in accordance with their preference. In their response the Approved Provider noted that education on how to document in the service’s electronic care system has been completed by registered staff. While a completion date for this education was not provided, an overview of the education provided reflected it encompassed assessment and planning and professional development for registered nurses; including high impact risks, compliance, centre person care and Aged Care Standards guidance and principles.

I acknowledge the Approved Providers actions to address the findings of the Assessment Team; however, at the time of the site audit information about the consumers’ condition and preferences was not consistently documented or communicated. Therefore, I find the service Non-Compliant in this requirement.

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

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

In coming to a decision of compliance in relation to this requirement, I have considered the information brought forward by the Assessment Team under this and other Quality Standards, including Standard 2.

While the service demonstrated referrals to medical and allied health professionals, and other specialists were mostly made in a timely manner, this was not occurring for consumers who required review by the dietitian. There was no process to ensure the dietitian was aware of consumers who required assessment. The dietitian advised the Assessment Team they were unable to enter healthy weight ranges for consumers in the service’s electronic care management system, to ensure an alert was raised if a consumer’s weight changed.

The Approved Provider in its written response to the Assessment Team’s findings acknowledged there had been no referral system organised with the dietitian service, which had resulted in non-timely referrals for some consumers. It was noted the dietitian had not utilised the service’s electronic care management system until recently. The Approved Provider stated further education is to be provided to all registered nurses on the email referral system and referrals will be based on an as needed basis. A referral folder, to be located in the nurses station, is to be implemented to house all copies of relevant email referrals. While the Approved Provider noted this newly established system had resulted in more timely referrals, education and support to be provided to the dietitian in relation to using the service’s electronic care management system has not specifically been addressed.

It was identified that consumer monitoring such as weighs, required to be undertaken by staff to support the referral to the dietitian, were not consistently being completed as part of the service’s ‘Resident of the Day’ review processes. The dietitian had advised the Assessment Team that during the site audit they were unable to find weights recorded for 11 consumers. In their response the Approved Provider noted the service was in the process of transitioning from their paper based system to their weight charting entered directly into the service’s electronic care management system; so that reports can be developed, and action plans initiated. A message of the day in the service’s electronic care management system reminds staff weights are to be monitored, and where weights are out of range, the system will send an alert to notify staff.

While I acknowledge the commitment of the Approved Provider to improve timely referral management, these processes were not effective at the time of the site audit and will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

*Minimisation of infection related risks through implementing:*

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

Staff demonstrated an understanding of how they minimise the need for use of antibiotics, including good hygiene practices and encouraging fluid intake for consumers. However, registered nurses were unable to describe how they would ensure antibiotics were used appropriately and the practices to promote appropriate antibiotic prescribing; management reported registered nurses had not received education in antimicrobial stewardship at the time of the site audit. While consumers’ infections were reported and monitored via clinical incidents in the service’s electronic care management system, management stated not all registered nurses were familiar with completing the infection form in the system; this was being addressed by provision of education.

The Approved Provider in its written response to the Assessment Team’s findings, and through their provision of the service’s plan for continuous improvement, reported education on Antimicrobial Stewardship has been completed by registered nurses with a key focus on and how to practically apply these. The pharmacist is to regularly review and report on variances to consumers’ antibiotic usage monthly and an internal Antimicrobial tracker has been commenced by the service. The Approved Provider is to engage a national medication management specialist to provide further advice when required and to provide consumer Residential Medication Management Reviews.

At the entry meeting for the site audit, management had advised the Infection Prevention and Control lead had left the service. While management was identifying a staff member to replace them and complete the Infection Prevention and Control training, clinical management were overseeing infection prevention and control program at the service in the meantime. During the site audit two medical and allied health professionals were observed not wearing facemasks when they visited the service, in line with the Queensland Health-Aged Care Directives.

In its written response the Approved Provided stated a named registered nurse has been identified as the service’s new Infection Prevention and Control lead and is scheduled to have required training. The Care Manager will continue to oversee all aspects of the service’s infection prevention and control program, until the new Infection Prevention and Control lead is trained; the Approved Provider is considering a backup position for each service. The Approved Provider reported that all regulations regarding COVID-19 are communicated to all staff, consumers and visitors via various mechanisms. Administration staff have received further education in relation to their role in monitoring visitors and contractors to the service, about signing in and the use of personal protective equipment when needed.

While I acknowledge the immediate and planned actions undertaken and committed to by the approved provider, at the time of the site audit, practises to promote appropriate antibiotic prescribing and use had not been implemented, and the minimisation of infection related risks relating to COVID-19 were not ensured in line with the Queensland Health-Aged Care Directives. Therefore, it is my decision this requirement is Non-Compliant.

# STANDARD 4 COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Consumers considered they got the services and supports for daily living that were important for their health and well-being and that enabled them to do the things they wanted to do; this included participating in activities as a part of the service’s lifestyle program and/or spending time on independent activities of choice. Consumers/representatives described ways in which consumers were supported to maintain social and emotional connections with those who were important to them. Consumers provided positive feedback in relation to food and confirmed it was of adequate quantity, high quality and variety.

Care planning documents included adequate information about what was important to the consumer and the supports needed to help them do the things they wished to. Documentation reflected the involvement of others in the provision of lifestyle supports. Reviewed consumers’ diet preferences identified consumer dietary requirements and preferences were captured, and this information was available to guide staff practice.

Lifestyle staff said they regularly sought feedback from consumers/representatives about the consumer’s social and activity preferences via a variety of mechanisms including completion of surveys and consumer meetings; this assisted in the development of future activity calendars. Care staff advised on ways they would offer emotional support to consumers, spend time talking with them about their concerns or topics that were of interest to them as a distraction. Staff provided examples of how the service supported consumers to participate in the community and/or keep in touch with the people important to them. Management advised the service had a quarterly food focus meeting as a specific forum to discuss all matters related to food; feedback and suggestions from the meeting were incorporated into the menu.

Reviewed monthly activity calendars demonstrated there were a variety of activities offered to meet the different needs and preferences of consumers. A variety of information brochures and resources were available to support referral to external organisations for assistance as required. Equipment to support consumers to engage in lifestyle activities were observed to be suitable, clean and well maintained. Consumers were observed engaging in a variety of group and independent activities during the site audit, and interacting with each other, staff, family members and visitors.

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

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Consumers considered that they felt they belong in the service and felt safe and comfortable in the service environment. Consumers said they felt at home, providing examples of how the gardens and the communal areas provided a nice living environment. Consumers advised the service was clean and well maintained.

The service environment was observed to be clean, tidy and well maintained; manual handling equipment was clean and suitable for the consumers at the service. Consumers were observed to move freely throughout the service and could access the external environment, which included walkways, gardens and outdoor seating areas.

However, the designated smoking area for consumers at the service did not adequately demonstrate consumers who smoked were able to do so safely; there was no provision of fire safety equipment or an access point for consumers to notify staff if they required assistance.

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

## Assessment of Standard 5 Requirements

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

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

### Requirement 5(3)(b) Non-compliant

*The service environment:*

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

While the service environment was observed to be clean, well maintained, comfortable and enabled consumers to move freely throughout the service environment, the designated smoking area was discerned to be not safe for consumers who smoked. Consumers smoked under a portable gazebo in the rear garden of the service, an ashtray was provided for their use. However, firefighting equipment was not near, or in view of the smoking area and an access point to alert or call for staff assistance was not available. Three named consumers who smoked and were observed to use the designated smoking area, had been diagnosed as cognitively impaired.

The Approved Provider in its written response to the Assessment Team’s findings, and through their provision of the service’s plan for continuous improvement, reported the current temporary gazebo has been removed as the structure would not withstand the local tropical cyclone weather. Consumers will be engaged in the discussion regarding a designated smoking area in the interim and then a permanent structure will be erected. The Approved Provider noted any permanent structure will need to satisfy the building code cyclone standards and require local council planning and building approval, a typical timeline of 12 months. Until a permanent structure is erected, the organisation is considering installing a temporary structure, which will be required to satisfy cyclone resilient requirements. Fire blankets and a small fire extinguisher have been provided for the current smoking area. Smoking aprons have been ordered, a flameless lighter is being sourced and emergency pendants have been purchased for consumers.

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers considered that they were encouraged and supported to give feedback and make complaints, and that appropriate action was taken. Consumers advised they could make complaints, felt safe to do so and were aware of various avenues available to provide feedback. Consumers noted the service responded to complaints and feedback; while most consumers/representatives said they had not needed to raise any complaints, those that had provided feedback reported they were satisfied with the response from the service

Staff demonstrated an awareness of the complaint’s mechanisms available at the service and described how they responded if a consumer raised an issue or concern; this included acknowledging their concern and escalating to a supervisor. Staff said no consumers at the service currently require translator services; however, were aware of links with the Aboriginal community they could access for consumers that might require these. Management described how feedback and complaints were reviewed and used to improve the quality of care and services.

An electronic system was observed in the reception area that consumers/representatives, staff and other visitors could access to provide feedback. Other avenues were also observed, which included a locked feedback box and feedback forms available in the reception area of the service. Posters in relation to external support and advocacy agencies were observed located throughout the service, with information brochures on display in the reception area.

The organisation has policies and procedures to guide staff in relation to management of feedback and said they had been provided with training on open disclosure. Review of a complaint report provided identified compliments, complaints and feedback for the service were addressed; this included trending on the number and types of complaints.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Consumers considered that they got quality care and services when they needed them and from people who were knowledgeable, capable and caring. Consumers/representatives reported staff were kind, caring and treated the consumer respectfully. Consumers/representatives were satisfied with the number of staff available and advised staffing numbers were adequate to meet the consumers care needs.

Registered staff said they had enough time to monitor the delivery of care and services by the care staff and were able to escalate issues to clinical management if needed. Interactions between staff members and consumers were observed to be kind, caring and respectful.

While staff interviewed advised they had not completed a recent performance appraisal, the Approved Provider in its written response to the Assessment Teams findings noted performance reviews are completed one year post commencement date of a new employee. As the service has not yet been in operation for 12 months, formal review meetings are yet to be held.

However, the service did not demonstrate registered nurses had the required skills and knowledge to effectively and safely deliver care for aged care consumers. While organisational processes were in place to enable the workforce to be trained, equipped and supported to deliver the outcomes required by these Standards, they were not effective and did not ensure the workforce was adequately trained, recruited and competent in their respective roles.

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

## Assessment of Standard 7 Requirements

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

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

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

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

### Requirement 7(3)(c) Non-compliant

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

While the workforce was generally competent and had the qualifications to perform their roles, the service did not demonstrate registered nurses had the required skills and knowledge to effectively and safely deliver care for aged care consumers. Recently qualified registered nurses who were appointed at the service, did not have aged care experience. While these registered nurses were being rostered to work with and be supported by clinical management, this had not always occurred, and the newly graduate registered nurses were not provided with additional guidance; the Assessment Team identified deficiencies in assessment and care planning, and in care delivery.

The Approved Provider in its written response to the Assessment Team’s findings, advised their external aged care consultant has delivered bespoke training (May 2021) to ensure staff understand clinical risk, high impact and high prevalence risks and are able to design and implement care that minimise these risks. Training has also been provided on ‘consumer engaged case conferencing and care planning, bringing evidence based practice and the Quality Standards together for an exceptional lived experience’ (May 2021). A clinical meeting will be formatted to be held monthly, chaired by clinical management, to discuss and case manage clinical care. There will be an opportunity for registered nurses to participate in the organisations new graduate training program.

While I acknowledge the commitment of the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

### Requirement 7(3)(d) Non-compliant

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

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard.

While consumers said staff knew what they were doing, deficiencies were identified in the knowledge of registered and care staff in relation to their use of the service’s electronic care management system. The service provided staff with a variety of training modules that were assigned in accordance with role descriptions; however, reviewed staff training records (education tracker) reflected the service was unable to evidence staff have completed mandatory and competency training as required. Identified skill gaps included registered staff not consistently completing assessment and care planning, including consideration of risk, care plans were not consistently reflective of consumer’s care needs or reviewed in line with the service’s review processes, and consumers changed care needs were not monitored post falls when required. Management advised they were addressing the skills gaps identified by providing additional training and workshops for these staff; management had said the current cohort of registered nurses were not trained in the Quality Standards.

The Approved Provider in its written response to the Assessment Team’s findings, stated education is being organised in relation to the service’s electronic care system to ensure it is maximised and all staff understand how to use it, this training is to be provided by the electronic software vendor. The approved Provider advised they are committed to providing education and development opportunities for all staff; all training modules are monitored by human resources for completion and reminders sent to all staff as required. While a staff training calendar for 2021 was provided, staff training not being completed via the education tracker was not specifically addressed.

The Approved Provider reported all registered nurses are to participate in two days of education based on the needs of the consumers they care for and identified gaps in practice and knowledge, which is to be delivered by external providers. Education on the Quality Standards has been provided by the external aged care consultant (May 2021) and Commission based training ‘Getting to know the Aged Care Quality Standards for aged care staff’ has been completed; the date this training was completed was not provided.

While I acknowledge the commitment of the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

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

The Assessment Team identified the service did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Staff interviewed advised they had not completed a recent performance appraisal and could not remember when one was last completed.

The Approved Provider in its written response to the Assessment Team’s findings, noted performance reviews are completed one year post the commencement date of a new employee. A performance review calendar provides regular updates for management to track upcoming performance reviews to be completed. As the service has not yet been in operation for 12 months, formal review meetings are yet to be held and documented. The Approved Provider stated in cases of under performance in the first 12-months of employment at the service, formal performance management practices in the form of letters and meetings with management (including informal file notes taken) are common practice to ensure staff are provided

feedback where required prior to the first annual performance review. Such letters, meetings and performance/conduct feedback has been provided to a number of staff members at the service since its commencement of operations date.

Additional actions implemented by the Approved Provider include a process has been developed to ensure probation reviews are occurring as per policy. The new process provides better oversight for the Area Managers and Human Resource teams, to ensure these reviews have been completed in the initial six months of employment for staff at the service. The organisation’s orientation process has

been reviewed and a booking system (that now forms part of the employee/manager

induction checklist) has been created which will help ensure all new staff at the service attend the full day organisation orientation program held each month.

In reviewing the information above, I am satisfied the service monitors and reviews the performance of staff and I find this requirement is Compliant.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Consumers considered that the organisation was well run and that they could partner in improving the delivery of care and services. Consumers were actively engaged in the development, delivery and evaluation of care and services and were supported in that engagement. The governing body meets regularly, sets clear expectations for the organisation and regularly reviews risks from an organisational and consumer perspective.

While the service was able to demonstrate effective governance processes relating to financial governance, regulatory compliance, and feedback and complaints; systems and process relating to information management, continuous improvement and workforce governance were ineffective. The organisation has risk management process in place; however, the service was unable to demonstrate there are effective risk management systems and practices in place.

The organisation has policies and processes for antimicrobial stewardship to guide staff in the use and monitoring of antibiotics; however, registered staff have not been provided with training and do not have an understanding of antimicrobial stewardship.

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

## Assessment of Standard 8 Requirements

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

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

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

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

### Requirement 8(3)(c) Non-compliant

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

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

While the service was able to demonstrate effective governance processes relating to financial governance, regulatory compliance, and feedback and complaints; systems and process relating to information management, continuous improvement and workforce governance were not ineffective. Unresolved issues in the service’s electronic care system impacted negatively on clinical tasks being completed and management had advised incomplete care documentation and risk assessments for consumers was related to staff not understanding how to use the electronic care system. The service’s continuous improvement processes had failed to identify and effectively action the deficits in care and services that had been identified by the Assessment Team at the time of the site audit. Workforce governance processes have not effectively ensured that staff at the service have the required knowledge and skills to perform their role. This has resulted in negative outcomes for consumers.

The Approved Provider in its written response to the Assessment Team’s findings, reported the Care Quality and Compliance team have hired a fulltime resource to focus on data, analytic and system management capabilities. Since the commencement of this role there has been review and enhancements to the service’s electronic care system and streamlining of processes and incident recording through an online safety framework. A business intelligence online platform is being introduced by the organisation to provide real time dashboard style information, so the service managers can actively manage issues on the day rather than retrospectively. Auditing and benchmarking is now undertaken through an industry recognised set of tools, which allows the organisational review of site incident data and compare it to other sites and industry.

The Approved Provider stated plans for continuous improvement at site level are an area of focus. Benchmarking results are interpreted, and interventions included in the service’s plan for continuous improvement. A new initiative of the Care Quality and Compliance team is to allocate team members to specific services to assist the area managers to ensure the information in the service’s plan for continuous improvement encompass the required information, and the improvement is closed. The Approved Provider noted the workforce have clear roles and responsibilities with the introduction of registered leads for consumers. However, the Approved Provider did not specifically address that staff at the service do not have the required knowledge and skills to perform their role, under this requirement.

I have taken into consideration the Assessment Teams report, the Approved Providers response and my findings in relation to Standard 2, Standard 3, Standard 5, Standard 7 and Standard 8, which demonstrate that these governance systems were not effective at the time of the site audit. While I acknowledge the commitment of the Approved Provider to address the deficiencies identified, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

### Requirement 8(3)(d) Non-compliant

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

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

The organisation’s governance and quality framework documented risk management strategies and guidance to assist in providing risk management strategies which included consideration of clinical care risks, the identification of potential elder abuse and neglect and how the service and organisation could support consumers to live their best life. However, the service was not able to demonstrate how each consumer was supported to take risks through the completion of risk assessments individualised for each consumer, the implementation of strategies to mitigate or manage the risks, and that discussion of the risks and management strategies with the consumer and/or their representative occurred. The service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Risks were not consistently mitigated and/or managed particularly in relation to monitoring of consumers who experience falls.

The Approved Provider in its written response to the Assessment Team’s findings, stated managing high prevalence and high impact risks is now supported by a new policy and procedure authored by an external aged care consultant. This document will be used to support the service to identify and manage high impact and high prevalence risk. Incident reporting continues in the service and nationally; all data associated with high impact and high prevalence risk is collected and communicated to the organisation’s Mission Council (Board). Quality auditing and benchmarking ensures that data associated with high impact and high prevalence risk is collected

and monitored.

While the approved provider has reported risk assessments for consumers have been updated since the site audit, risk assessment and management processes were not effective at that time. I acknowledge the improvements implemented by the Approved Provider to address the deficiencies identified; however, these improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

### Requirement 8(3)(e) Non-compliant

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

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

The service was unable to demonstrate that where clinical governance is provided, an appropriate clinical governance framework is in place. While the organisation was able to demonstrate it had policies and processes relating to antimicrobial stewardship, minimising the use of restraint and open disclosure, the service was unable to demonstrate that registered staff had received training in and understood the principles of antimicrobial stewardship.

The Approved Provider in its written response to the Assessment Team’s findings, said the organisation’s current clinical governance framework is under review to follow more closely to the Aged Care Quality and Safety Commission guidance on the development of a clinical governance framework. The revised clinical governance framework will incorporate the enhancements to systems in place to measure and monitor quality and safety as well as the best practice guidelines that are being developed. The Approved Provider has purchased a national medication management specialist’s policy and procedure document, it has been reviewed with view to incorporate as an appendix the Infection Control Procedure. Antimicrobial

Stewardship, while appearing in the current procedure, will be enhanced with this information. Education on Antimicrobial Stewardship has been completed by registered nurses with a key focus on and how to practically apply these.

While I acknowledge the improvements implemented by the Approved Provider to address the deficiencies identified, these improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

# 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.

* Each consumer is to be supported to take risks to enable them to live the best life they can.
* Assessment and planning is to include consideration of risks to consumers.
* Care and services are to be reviewed regularly for effectiveness.
* Effective management of high impact or high prevalence risks.
* Information about the consumer’s condition, needs and preferences is to be documented.
* Timely and appropriate referrals are to be undertaken.
* Minimisation of infection related risks through implementing standard infection processes and appropriate antimicrobial stewardship.
* The service environment is to be safe.
* The workforce is competent and have the qualifications and knowledge to effectively perform their roles.
* The workforce is trained, equipped and supported to deliver the outcomes required by these standards.
* Effective organisation wide governance systems are to be established that include information management, continuous improvement and workforce governance.
* An effective risk management that includes managing high impact or high prevalence risks associated with the care of consumers.
* A clinical governance framework that includes antimicrobial stewardship.