Performance

Report

**1800 951 822**

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| Name: | Allanvale Private Nursing Home |
| Commission ID: | 4302 |
| Address: | 38-40 Ascot Street South, ALTONA MEADOWS, Victoria, 3028 |
| Activity type: | Site Audit |
| Activity date: | 6 August 2024 to 9 August 2024 |
| Performance report date: | 12 September 2024 |
| Service included in this assessment: | Provider: 2699 Carewest Group Pty Ltd  Service: 2823 Allanvale Private Nursing Home |

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

**This performance report**

This performance report for Allanvale Private Nursing Home (**the service**) has been prepared by N Chahal, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received on 6 September 2024.

# Assessment summary

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

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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

Findings

The service was found not compliant with Requirements 1(3)(d) and 1(3)(f) following a site audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

Most consumers and representatives said staff are respectful, treat them as individuals, support cultural needs and preferences, and that care is inclusive and personalised. Service documentation and policy demonstrate how the service values culture, diversity, and inclusion by planning culturally appropriate activities and services. This was supported by consumer examples of language diversity and engagement in cultural communication. Consumers also confirmed they are supported and encouraged to participate in their religious and spiritual practices.

There was evidence to support that the service enables consumers to exercise choice and maintain relationships. Examples were provided, including consumers maintaining their independence through making their own decisions about the delivery of their care and maintaining social relationships and visits outside of the service. Care planning documentation reflected consumers’ goals and preferences for care including the people they want involved in their care.

Consumers and representatives confirmed the service supports them to take risks to enable them to live life as best they can. Examples included consumers being supported to exercise their preference for smoking and drinking following completion of risk assessments. Since the previous findings of non-compliance, the service has implemented processes and practices to support consumers in pursuing activities that maintain their independence while acknowledging the potential risks involved. These included door fobs being provided to consumers and representatives that enable them to enter and exit the service at any time and encouraging consumers to have their own electrical appliances in their rooms.

The service has various communication methods, including a bi-monthly newsletter, a consumer handbook, a monthly lifestyle activity calendar, menus, consumer/representative meeting information and general information pamphlets. These are displayed throughout the service. Consumers and representatives confirmed receiving regular communication from the service to keep them informed.

Consumers and representatives confirmed the service respects their privacy, and that their personal and health information is kept confidential. In response to the previous findings of non-compliance, the service has provided education to staff on maintaining consumers’ privacy. The Assessment Team observed staff knocking on consumers’ doors before entering bedrooms. Many consumers had ‘please knock before entering’ signs on their doors, treatment rooms and nurse’s stations doors were observed to be locked and consumer information was kept confidential.

# Standard 2

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

Findings

The service was found not compliant with Requirements 2(3)(a), 2(3)(c), 2(3)(d), and 2(3)(e) following a Site Audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

Consumers and representatives confirmed the service undertakes effective assessment and care planning processes. The service has a range of risk assessment tools to guide staff in the delivery of safe and effective care and services. A review of care documentation confirmed the service undertakes comprehensive assessments including but not limited to cognitive change, falls, weight loss, skin integrity, polypharmacy and environmental restrictive practice. Staff demonstrated knowledge of individualised risks associated with consumer care needs. In relation to the previous findings of non-compliance, the service has implemented improvements in the assessment of care and services, including overseeing and evaluating care plans and reviewing risks to consumers’ health and well-being.

Overall, consumer care documentation recorded current consumer needs, and this was confirmed by the consumers and representatives. Staff described the service’s process of developing advance care directives in consultation with consumers and representatives. The Assessment Team noted some inconsistencies in care plans, this was addressed by management and included in the service’s Plan for Continuous Improvement (PCI) at the time of the Site Audit.

Consumers and representatives confirmed their involvement in planning care. The Assessment Team sighted documentation confirming effective involvement of other providers, including medical officers and physiotherapists, contributing to the planning and review of care and services. In response to the previous findings of non-compliance, the service has implemented effective communication of the outcomes of assessment and planning along with offering care plans to consumers and representatives. This was confirmed through consumer and representative interviews.

The service has established processes to undertake regular and as needed review of consumer care needs; for example following incidents and changes in circumstances. Staff described two-monthly evaluation and daily review of consumers’ care needs through handovers and progress reports. A review of consumer care documentation demonstrated comprehensive review of clinical assessments relating to skin integrity, falls risk and pain following changes to consumer mobility.

# Standard 3

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

Findings

The service was found not compliant with Requirements 3(3)(a), 3(3)(b), 3(3)(e), 3(3)(f) and 3(3)(g) following a Site Audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

During the site audit in August 2024, the Assessment Team recommended that Requirement 3(3)(g) was not compliant. However, with consideration to the available information and the Approved Provider’s response, I consider Requirement 3(3)(g) compliant.

Requirement 3(3)(g)

The Assessment Team observed the service’s infection control processes as ineffective, and improvement strategies following the Site Audit in July 2023 had not been fully implemented to enable management to have oversight of the potential infection-related risks. During the August 2024 Site Audit, the Assessment Team observed a breakdown in the visitor entry/screening process increasing the risk of infection to consumers. The service did not have a dedicated infection prevention and control lead (IPCL) onsite and the service’s key meeting minutes did not reflect consideration of infection control risks.

The Approved Provider submitted a response to the Assessment Team report disagreeing with the Assessment Team’s recommendations. The response included further clarifying information and supporting documentation such as invoices for IPCL consulting services, position descriptions, risk assessments, end of month reports and meeting minutes.

In relation to the dedicated IPCL, the service is currently receiving infection control support both on site and remotely and has clinical staff currently completing IPCL training. The Approved Provider acknowledged that infection control risks were omitted from a key meeting in July 2024, however there was evidence submitted to demonstrate this was discussed at the clinical care meeting in July 2024 and included in the agenda for the work health and safety committee meeting in August 2024.

The Approved Provider acknowledged the breakdown of the entry process at the time of the August 2024 Site Audit and submitted a PCI with action items planned and completed. These actions included a review of infection control audits, streamlining the visitor entry process through purchase of a standing thermometer, electronic visitor entry and a stocktake of Personal Protective Equipment (PPE) supplies by the IPCL. The response described the current entry process in detail and explained that at the time of Site Audit, the usual visitor entry practice was interrupted due to unplanned staff leave.

I acknowledge the Assessment Team’s observations and have placed weight on the evidence submitted in the Approved Provider’s written response to the Assessment Team report. Whilst I acknowledge the deficits in the entry process during the Site Audit, I am satisfied the Approved Provider has demonstrated it has effective systems in place to minimise the risk of infection to consumers. I encourage the Approved Provider to continue embedding planned actions from the PCI into usual practice. I find this Requirement is compliant.

In relation to Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), and 3(3)(f) I am satisfied that the service implemented several effective actions in response to the identified non-compliance in July 2023.

Consumers and representatives confirmed the provision of safe personal and clinical care that meets their needs and preferences. The service demonstrated effective management of restrictive practices, psychotropic medication and changed behaviours; this was confirmed through review of consumer care documentation demonstrating detailed behaviour support plans, informed consent and ongoing review of the mechanical and environmental restrictive practices. There is evidence to support that the service provides appropriate wound and pain management for consumers; this has been confirmed through review of wound charting and involvement of a wound consultant. The service has policies and procedures for key areas, including but not limited to restrictive practices, behaviour, wound and pain management.

The service demonstrated effective management of high impact and high prevalence consumer risks related to diabetes, falls and nutritional requirements. A review of consumer care plans and assessments reflected that high impact and high prevalence risks are consistently managed in alignment with the service’s processes and procedures using a multidisciplinary approach. Consumers and representatives confirmed the service provides care to effectively manage associated risks. Staff provided examples of individualised consumer risks and associated risk mitigation strategies. Documentation demonstrated inclusion of recommendations from clinical care and allied health staff.

Consumers and representatives were satisfied with the service’s approach to care as consumers near the end of life. The service has organisational policies and procedures to guide the provision of palliative care and ensure end of life needs are met in line with consumer wishes, and comfort is maintained.

The service has processes, policies and procedures to recognise and respond to deterioration in a timely manner. Consumers and representatives were satisfied that this occurs. This was supported by the example of a consumer who had experienced clinical deterioration following which they were assessed by clinical staff and referrals made to the medical officer and allied health specialists, to effectively manage the change in condition.

Consumers and representatives confirmed that consumer needs and preferences are effectively communicated. Management and staff described a range of communication mechanisms available for sharing consumer information and demonstrated knowledge of the needs and preferences of each consumer. Care documentation demonstrated consumer conditions, needs and preferences are communicated, and information exchange occurs with others who share responsibility for care.

Referrals are undertaken by staff in a timely manner, with evidence in consumer care documentation of regular and ongoing contributions from general practitioners (GPs), physiotherapist, podiatrist, dietitian, speech pathologist, wound consultant and other healthcare providers. Consumers and representatives expressed satisfaction with their access to external health providers and multi-disciplinary specialists when required.

# Standard 4

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

Findings

The service was found not compliant with Requirements 4(3)(b), 4(3)(d), 4(3)(f) and 4(3)(g) following a Site Audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

The service supports consumers do things of interest to them and optimise their health, well-being, and quality of life. This was supported by examples confirming consumers engage in a variety of lifestyle activities and are actively involved in the development of the lifestyle program. Care documentation demonstrated the consumer’s individualised needs, goals, and preferences in care and services to support social or spiritual well-being.

In response to the previous findings of non-compliance the service has introduced a well-being staff shift, dedicated to ensure one-on-one quality time is spent with the consumers and person-centred activities are undertaken. There was evidence of consumers receiving emotional and psychological support from staff. The service engages with a variety of organisations that are of importance to consumers including churches and entertainers. Staff demonstrated knowledge of the current concerns of consumers and factors affecting emotional or spiritual well-being, and there was evidence of support in line with care planning documentation.

There was evidence to support that the service encourages consumers to participate in the service community and maintain their personal relationships, and to do things of interest to them. Consumers confirmed staff respect their privacy and encourage them to maintain social and personal relationships. Staff demonstrated knowledge of individual consumer preferences and respect for consumers’ relationships of importance. Care planning documentation outlined consumers’ individualised interests and social relationships.

Consumers expressed satisfaction with the communication between providers of their care and confirmed that staff understand their needs. In response to the previous findings of non-compliance, the service implemented an effective handover system along with ensuring appropriate orientation for agency staff. Staff and external providers of care gave positive feedback about the communication of information related to consumer condition, and confirmed they felt well-informed of consumers’ needs, goals and preferences.

The service demonstrated that timely and appropriate referrals are made to individuals, other organisations, and providers of other care and services. This was supported through the review of care documentation. Consumers confirmed referrals were made in a timely manner and that they could access other organisations as needed. Staff were able to describe the referral process.

Consumers and representatives confirmed receiving meals of sufficient variety, quality and quantity. The service has reviewed and recorded consumers’ dietary needs and preferences, and this information is made available to kitchen staff. This was implemented in response to the previous findings of non-compliance. Catering and care staff demonstrated knowledge of individual consumers’ requirements and preferences. The service seeks consumer feedback through food focus meetings and at consumer/representative meetings. During the Site Audit, staff were observed to not refer to the dietary list and were uncertain regarding the preparation of a modified drink. Management acknowledged the feedback and organised a speech pathologist to provide staff training on modified diet and fluids.

Consumers and representatives were satisfied that the equipment provided to them is safe, clean and well maintained. Staff confirmed access to a range of equipment, described the equipment used to support consumers, and outlined how they ensure it is safe or suitable. The Assessment Team observed equipment to be clean, well-maintained, and suitable to meet the needs of consumers. The service has implemented improvements in response to the previous findings of non-compliance, which included review of checklists to ensure consumer equipment is cleaned regularly, a thorough review of the cleaning duties of the care and cleaning staff and including equipment cleanliness in the internal audit list.

# Standard 5

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

Findings

The service was found not compliant with Requirements 5(3)(b) and 5(3)(c) following a site audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

Consumers and representatives confirmed the service environment is welcoming and optimises each consumer's sense of belonging, independence, interaction and function. Consumers’ rooms were personalised with family photos and personal furniture. There was evidence of an individualised approach to consumers, promoting a welcoming environment. Management and staff described supporting consumers to bring personal items into their rooms to optimise their sense of belonging.

The service has implemented daily cleaning schedules in response to the previous findings of non-compliance. The Assessment Team observed the service to be clean and well-maintained. Consumers and representatives described the service environment as safe, clean, and well-maintained. They confirmed they can access all areas of the service, with the freedom to leave the service independently or with their representatives. The service has processes in place including a maintenance schedule and cleaning checklists to monitor task completion.

Consumers and representatives said they are satisfied with the maintenance of furniture, fittings, and equipment, and that they are safe. The Assessment Team’s observations aligned with these reports. Since the previous findings of non-compliance, the service has reviewed the preventative maintenance schedule to include cleaning of consumer furniture.

# Standard 6

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

Findings

The service was found not compliant with Requirements 6(3)(a), 6(3)(b), 6(3)(c), and 6(3)(d), following a site audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

Consumers and representatives expressed confidence in raising a complaint and confirmed various mechanisms to raise and resolve complaints, including the use of feedback forms. As a result of the improvements implemented since the July 2023 Site Audit, the service has secure feedback boxes, and information and support is provided to consumers and representatives to assist them to provide feedback. Staff demonstrated knowledge of language and advocacy services and provided examples of supporting consumers and representatives in the complaints process. The service supports consumers to access additional support through the Older Person’s Advocacy Network (OPAN), which was supported by evidence from consumer examples.

The service has streamlined the complaints process using electronic systems that enable appropriate delegation, action and follow-up on complaints and feedback. Consumers and representatives confirmed the service addresses their concerns and uses them to improve the quality of care and services. An example included improvements to the service environment. Staff demonstrated an understanding of the principles of open disclosure and the complaints handling process. Staff and management described how complaints are analysed and used to make improvements to the quality of services.

# Standard 7

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

Findings

The service was found not compliant with Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e) following a site audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

Most consumers were satisfied with staffing arrangements and call bell response times. Most had noticed a reduction in the use of agency staff, implemented by the service in response to the previous findings of non-compliance. Representative feedback reflected an improvement in call bell response times. While a small number of consumers and representatives were not satisfied with weekend staffing, the Assessment Team noted the service meets its care minute obligations and management regularly reviews the roster to ensure staffing enables consumer needs to be met. Contracted hours have been reviewed to ensure permanent shifts for staff, and a new position is being trialled to increase the emotional support available to consumers.

Consumers and representatives confirmed staff are kind and respectful, describing a warm approach during the provision of care. Staff have knowledge of consumer culture and identity and tailor their approach to suit each individual.

The Assessment Team report reflected staff are competent. Staff are aware of consumer needs and provide appropriate care. They are required to complete competencies, and nursing and allied health staff provide evidence of qualifications annually.

Training for staff has been improved since the previous findings of non-compliance, and most consumers and representatives could not identify any areas of deficit in staff skills or knowledge. There was evidence that when incidents occur staff are required to repeat relevant training. The training provided includes the Serious Incident Response Scheme (SIRS) and texture modification and thickened fluids.

Since the previous findings of non-compliance, the service has introduced performance appraisals. These have occurred for most staff and are continuing. Policies and procedures are in place for the monitoring and review of staff performance, and there was evidence disciplinary action is taken if necessary.

# Standard 8

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

Findings

The service was found not compliant with Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) following a site audit conducted in July 2023. Since that time, the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with all Requirements and as a result is compliant with this Standard.

During the site audit in August 2024, the Assessment Team recommended Requirements 8(3)(b) and 8(3)(d) as not compliant. However, with consideration to the available information and the Approved Provider’s response, I am satisfied that Requirements 8(3)(b) and 8(3)(d) are compliant.

Requirement 8(3)(b)

The Assessment Team found the governing body did not meet legislative requirements for independent members with diverse skills, experience and expertise to ensure safe and quality care for consumers. The Assessment Team also found the service did not have adequate records of key committee meetings or clinical reporting to provide to the Assessment Team.

The Approved Provider submitted a written response with clarifying information and documentation including meeting minutes and clinical reports.

The response included information about the governing body membership. It documented the composition of the Board, confirming it meets legislative requirements with the correct mix of members, clinical independent non-executive members and one executive member. The Approved Provider is also completing an induction process for another clinician to join the governing body.

In relation to key committee meetings, the service has an established electronic process to record meeting minutes and the Approved Provider has planned to undertake a review of this process for its effectiveness and continuous improvement. The response clarified the service’s terminology used for the clinical reports provided to the Assessment Team at the time of the Site Audit. I accept the documents titled ‘end of month analysis’ as those reflecting clinical reporting information.

Requirement 8(3)(d)

The Assessment Team report identified that the service’s risk management system did not manage high-impact and high-prevalence risks. There was evidence that entry processes did not support minimising risk of infection to consumers, and that management and monitoring of hydronic heaters located in common areas was inadequate to minimise the risk of burns and other related harm. The service did not demonstrate a robust incident management system relating to the Serious Incident Reporting Scheme (SIRS).

The Approved Provider submitted a written response with clarifying information and documentation including clinical information reports.

In relation to the management and monitoring of hydronic heaters, the Approved Provider described the steps they have undertaken to reduce the temperature of the heaters along with establishing a process for ongoing maintenance and temperature monitoring. The risk associated with hydronic heating has also been noted in the risk register.

The Approved Provider described their current SIRS process as a manual paper-based system with plans to convert this into an electronic system. The service described and submitted evidence demonstrating that all incidents including SIRS incidents are analysed and trended monthly through clinical reporting. The Approved Provider acknowledged that currently access to SIRS incident reporting is only available to the executive management, however additional access is being provided to clinical management.

In relation to the minimisation of risks related to infection control, the Approved Provider submitted a PCI with action items completed and planned to ensure effective visitor entry processes. I have also considered this information under Standard 3, Requirement 3(3)(g).

I have reviewed all the available information and have placed weight on the Approved Provider’s response and submitted evidence including clinical reports and meeting minutes. I find Requirements 8(3)(b) and 8(3)(d) compliant.

In relation to Requirements 8(3)(a), 8(3)(c), and 8(3)(e), the service has implemented initiatives resulting in improvements, and as a result I am satisfied the service is compliant with these Requirements.

The service now has a consumer advisory board (CAB), and documentation reviewed by the Assessment Team confirmed consumers and representatives are provided opportunities for input and contribution to the delivery of care and services. Consumers and representatives confirmed their participation in the CAB and confirmed their involvement in the evaluation and development of care through consumer/representative meetings.

The service has implemented effective organisation wide governance systems related to information management and access to an online platform for policies and procedures. Consumers and representatives confirmed the service undertakes continuous improvement activities. A review of the PCI reflected improvement activities were driven by the non-compliance identified at the July 2023 Site Audit. Financial governance is overseen by management and reported to the governing body. There was evidence of effective workforce governance through the planned and monitored workforce, and the service has an overarching workforce strategy. The service monitors and incorporates feedback and complaints into their continuous improvement activities and remains up to date with regulatory compliance through aged and community care providers association membership.

There is evidence to support that the service has undertaken improvement activities to ensure compliance with restrictive practices, open disclosure and antimicrobial stewardship. Whilst the Assessment Team observed ineffective visitor entry processes to minimise the risk of infection to consumers, I have reviewed the response submitted by the Approved Provider and I am satisfied that the service has undertaken effective infection control practices to ensure consumer safety. I have also considered this information under Standard 3 Requirement 3(3)(g).

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