Performance

Report

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| Name: | Anglican Care Scenic Lodge Merewether |
| Commission ID: | 0900 |
| Address: | 251 Scenic Drive, MEREWETHER, New South Wales, 2291 |
| Activity type: | Site Audit |
| Activity date: | 29 January 2024 to 31 January 2024 |
| Performance report date: | 14 March 2024 |
| Service included in this assessment: | Provider: 3186 Anglican Care  Service: 6569 Anglican Care Scenic Lodge Merewether |

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 Anglican Care Scenic Lodge Merewether (**the service**) has been prepared by P. Wallner, 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 8 March 2024.
* other information held by the Commission.

# 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 | **Not 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

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

Requirement 3(3)(a) - Each consumer gets safe and effective personal and clinical care that is best practice, tailored to their needs, and optimises their health and well-being. This includes ensuring all use of restrictive practices is in accordance with regulatory requirements and consumers have reliable and timely access to medical officers attending the service.

# 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

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements have been assessed as Compliant.

Consumers said staff treated consumers with dignity and respect, and their identity, culture and diversity were valued. Staff showed an understanding of consumers’ individual backgrounds and identities and were observed treating consumers with dignity and respect. Care planning documentation contained information specific to consumers' backgrounds and cultures. The service had written policies and procedures to ensure consumer diversity and inclusion was supported.

Consumers and representatives confirmed the service recognised and respected their cultural background and provided culturally safe care and services. Staff described how they knew consumer’s cultural background and delivered to culturally safe care. Care planning documents detailed consumers’ cultural backgrounds and how to support their cultural needs and preferences.

Consumers and representatives said they were supported to maintain relationships of choice, make choices regarding their care and services, and who was involved in their care. Staff described how they supported consumers to make choices about their care and who was involved, maintain their independence and relationships of choice. Care planning documents detailed consumers’ care choices and their important relationships.

Consumers described how they were supported to make decisions which involved taking risks to live the life they chose. Staff described risks taken by consumers to live the life they chose, and the steps they took to support them and to minimise these risks. Care planning documents identified and assessed risks to consumers and recorded the agreed risk management strategies.

Consumers confirmed staff respected their privacy, such as by closing doors when providing care. Staff and management described practical ways they respected consumers’ privacy and kept their personal confidential. Staff were observed knocking on doors and closing doors to deliver care and computers were password protected and locked when unattended.

# 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

Consumers and representatives said they were involved in the assessment and care planning process, and they received the care they required. Staff and management described how the assessment and care planning process informed the delivery of safe and effective care and services, including risks to individual consumers. Most care planning documents reflected comprehensive assessment and care planning including the consideration of risks. However, some consumers subject to restrictive practices did not have documented assessments and consents in place and two consumer’s diabetes management plans were not current. These issues have been further considered under Requirements 3(3)(a) and 8(3)(e).

Consumers and representatives confirmed assessment and care planning identified their current needs, goals and preferences, as well as their advance care and end of life plans. Management and staff explained how the assessment and care planning process identified consumers’ current needs, goals, and preferences, and how they discussed end of life and advance care plans. Care planning documents included consumers’ current needs, goals and preferences, and end of life plans.

Consumers and representatives said they were partners in the assessment and planning of care however, some consumers and representatives described difficulties accessing a medical officer for clinical review in the past. Management and staff outlined how assessment and planning of care was done in partnership with consumers, and others they wished to involve in their care. Management acknowledged there had been difficulties getting a medical officer to attend the service over the December 2023 - January 2024 period and relied on the nurse practitioner to supplement the care over this period. Care planning documentation evidenced regular care plan evaluations and review in line with the service’s policies and included input from a range of external providers such as medical officers, dietitians, physiotherapists and speech pathologists.

Consumers and representatives said the service was proactive in communicating changes related to their care and services, and staff explained things to them. Management and clinical staff described how the outcomes of assessment and planning were effectively communicated to consumers, representatives, and others involved in providing care, and documented in a care and services plan that was readily available to the consumer.

Consumers and representatives confirmed the care and services were reviewed regularly and reviewed when changes in condition occurred. Management and staff explained the process for scheduled and ad hoc reviews of care plans. Consumers’ care plans evidenced reviews for effectiveness, regularly and when circumstances changed, or incidents impacted on the needs, goals, or preferences of the consumer. One consumer’s diabetes management plan was noted not to have been updated to reflect a review by the nurse practitioner regarding their blood glucose checks.

# Standard 3

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

This Quality Standard is assessed as Not Compliant as 1 of the 7 Requirements has been assessed as Not Compliant.

The Assessment Team recommended Requirement 3(3)(a) was Not Met. While consumers said they received safe and effective personal and clinical care, the Site Audit found not all consumers subject to restrictive practices had appropriately documented care plans and restrictive practice consents in place. I have also considered issues raised under Requirement 3(f) in relation to access to medical officers under this Requirement. Evidence brought forward included:

* Management was unable to correctly identify the number of consumers subject to restrictive practices at the entry meeting.
* Some consumers subject to forms of restraint did not have the required documentation, completed consents or Behaviour Support Plans, where applicable.
* Management demonstrated they had already raised a continuous improvement plan to audit all consumers for restrictive practices by 2 February 2024.
* The improvement plan includes a review of psychotropic medication usage and ensuring regulatory compliance for all use of restraint, such as documenting Behaviour Support Plans and informed consent.
* The spreadsheet tracking the audit of restrictive practices confirmed the review was well advanced.
* Four consumers/representatives expressed dissatisfaction with the availability and timeliness of visits by the medical officer however, only one identified negative impact.
* The representative of a consumer with a skin condition considered the lack of timely access to a medical officer to have adversely impacted the well-being of the consumer. The representative said the medical officer only comes once monthly.
* Management explained the consumer’s skin condition had been reviewed by the nurse practitioner, they were receiving active treatment, and they had been referred to the dermatologist.
* Most consumers and representatives expressed satisfaction with their access to medical officers and care planning documents evidenced the involvement of medical officers, allied health professionals, and other providers of care.
* Management and clinical staff described how other providers of care and services were accessed to ensure each consumer received safe and effective clinical and personal care.

The provider’s response received 8 March 2024, provided additional clarifying information and evidence in relation to the provision of safe and effective clinical and personal care. The provider advised:

* Prior to the Site Audit the service identified gaps in the psychotropic drug register and undertook a review of restrictive practices and psychotropic medications in line with organisation’s policies, and an improvement plan was created.
* The environmental restraint consent documents for consumers in the Memory Support Unit (not located during the Site Audit) were located and only one consumer was found not to have the appropriate signed consent form (which has now been rectified).
* The review identified only one consumer subject to a mechanical restraint, which was at their own request. These arrangements have now been changed following consultation with the physiotherapist and the consumer.
* The implementation of the improvement plan is well advanced with almost all consumers restraint status reassessed and correctly documented, including a behaviour support plan, where applicable. The service is awaiting third party input to be finalised for 3 consumers.
* The improvement plan has resulted in process improvements such as the creation of new registers to track consumers subject to restraint and improved medication charting.
* They experience occasional difficulties in accessing the services of medical officers onsite. The organisation communicates with the local Public Health Network and makes many other attempts to source medical officer services.
* The service made repeated attempts to find a medical officer over the January 2024 holiday period but was unable to find one willing to attend the service.
* The service uses various alternate strategies to meet the clinical care needs of consumers including using the organisation’s nurse practitioner, utilising the Aged Care Emergency Service (ACE), accessing the emergency department, or family taking consumers to external services.
* A new medical officer will be attending the consumers at the service from 11 March 2024.

I note the evidence of consumers subject to restraint not being appropriately identified and documented, and consumers/representatives concerns around timely access to medical officers at the service. I acknowledge the service had self-identified gaps in relation to restraint and is in the process of implementing planned improvement actions.

Timely access to appropriate health professionals is fundamental to supporting the clinical care of consumers in residential aged care. Alternative providers and contingency plans should be in place to ensure continuity of service over predictable periods of absence.

While the service has taken improvement actions, during and since the site audit, to address these deficits, it is too early to determine whether these actions are sustainable and effective in ensuring each consumer gets safe and effective personal and clinical care, consistent with best practice. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(a) Not Compliant.

The Assessment Team recommended Requirement 3(3)(f) was Not Met. While most consumers and representatives said referrals to other organisations and health professionals were timely and appropriate, the Site Audit identified 4 consumers/representatives that were not satisfied they had timely access to medical officers at the service. I have considered this issue under Requirement 3(3)(a) as it relates to routine clinical attendance by medical officer(s) at the service, rather than referrals to other providers.

I am satisfied the remaining 5 Requirements in Standard 3 are Compliant.

Representatives expressed satisfaction with how the service managed risks to consumers’ health and well-being. Management detailed the high-impact and high-prevalence risks relevant to the service and how they were monitored and managed. Staff described a range of effective risk mitigation strategies in place, which aligned with consumers’ care plans. The Site Audit identified one consumer with diabetes was not being regularly tested in accordance with their care plan. However, the consumer representative was satisfied with the diabetes care being provided by the service and said staff tested the consumer regularly and managed their diabetes medication. Management subsequently demonstrated they had updated the consumer’s diabetes management plan and added daily testing to the care task list which appears on the service’s electronic care management system and the shift handover sheet.

Consumers and representatives confirmed the service had initiated end of life planning conversations with them and expressed satisfaction with the end of life care provided to consumers. Staff explained how they recognised and addressed the needs and preferences of consumers nearing the end of life, and how they maximised their dignity and comfort. The service had written policies regarding palliative care and advance care to support staff practice.

Consumers and representatives said the service identified and responded to a deterioration or change in consumers’ health appropriately, and any management strategies were explained. One representative expressed dissatisfaction with the late detection of a pressure injury however, they were satisfied with the service’s subsequent response. Clinical staff explained how deterioration or change in condition would be identified, discussed during handovers, monitored and managed. Care planning documents confirmed changes in a consumer’s capacity or condition were recognised and responded to in a timely manner. The service had policies and procedures regarding deterioration to guide staff practice.

Consumers and representatives said current information about consumers’ condition, needs and preferences was documented and communicated effectively to them, and to staff and external providers involved in their care. Staff described how information about consumers’ needs, conditions, and preferences was documented and communicated within the organisation and with others responsible for providing care. Care planning documents provided adequate information to support safe and effective care and services.

Consumers and representatives expressed confidence in the infection prevention and control measures in place and said staff always practiced good hand hygiene. Staff understood the precautions necessary to prevent and control infections and the steps they could take to minimise the need for antibiotics. The service had appointed an infection prevention and control lead and had implemented documented policies and procedures to guide staff in antimicrobial stewardship and infection prevention and control.

# 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

Consumers and representatives said they received safe and effective services and supports for daily living that optimised their independence, health and quality of life. Staff described how they met consumers’ lifestyle needs, goals and preferences and optimised their independence, well-being, and quality of life. Care planning documents showed consumers received services and supports for daily living in line with their needs, goals and preferences.

Consumers reported their emotional, spiritual, and psychological needs were supported by the service. Care planning documents contained specific information regarding consumers’ social, emotional, and spiritual needs and preferences. Staff described how they identified when consumers were feeling low and gave practical examples of how they supported consumers’ emotional, spiritual, or psychological well-being.

Consumers said they were supported to participate in the community inside and outside the service, keep in touch with people they chose to, and do things of interest to them. Staff detailed how they supported consumers to maintain important relationships and do things they enjoyed. Care planning documents noted consumers’ lifestyle interests and the people that were important to them. Consumers were observed socialising and hosting visitors.

Consumers and representatives said information about consumers’ condition, needs, and preferences was communicated effectively within the service, and with others involved in providing care and services. Staff described ways current information about consumers’ condition, needs or preferences was effectively shared through care plans and shift handovers. Care planning documents recorded sufficient information to support safe and effective services and supports for daily living.

Consumers said they were referred to other individuals and organisations providing care and services, when needed. Care planning documents showed referrals to appropriate other organisations and services such as council community services. Staff described other external providers involved in the delivery of services and supports for daily living to consumers.

Overall, consumers and representatives expressed satisfaction with the variety, quality and quantity of the food provided, and said the meals met their needs and preferences. Consumers and representatives said they could provide feedback about the food and there were multiple options for meals and plenty of snacks throughout the day. Care planning documents recorded consumers’ dietary needs and preferences, and these were consistent with their interview responses. Staff were observed assisting consumers with their meals, and said they knew consumers’ dietary needs and preferences and ensured they were met.

Consumers said the equipment available was safe, suitable, clean and well maintained. Management and staff described how equipment was maintained and cleaned effectively. The equipment throughout the service was observed to be suitable, clean and well-maintained.

# 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

Consumers and representatives said the service environment was welcoming, easy to understand and navigate. Management and staff described how they encouraged consumers to personalise their rooms and made them feel welcome. Management and staff explained features of the service that optimised each consumers’ sense of belonging, independence, interaction, and function. The service environment appeared welcoming and easy to understand, with sufficient lighting, handrails and clear signage to provide directions. The service featured courtyards, lounges, dining and activities areas to promote belonging, independence, interaction and function.

Consumers and representatives said the service environment was safe, clean, well maintained, and allowed them to move around freely, as they wished. Management and staff described the processes in place to ensure the service was safe, clean, and well maintained, and consumers were supported to move freely, both indoors and outdoors. Cleaning records showed some gaps in cleaning had occurred, primarily in the cleaning of consumer rooms. Management advised they had self-identified a shortage of cleaning staff and they were recruiting additional cleaning staff and block booked agency cleaning staff.

Consumers and representatives said furniture, fittings and equipment were safe, clean and well maintained. Staff described their role and the processes in place for cleaning and maintaining the equipment, furniture, and fittings in the service. The furniture, fittings and equipment appeared safe, clean and well maintained.

# 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

Most consumers and representatives said they felt safe and comfortable providing feedback or making complaints, and described various ways they could do so. Management and staff described various processes in place to encourage and support consumers and representatives to provide feedback and make complaints. The service had written policies, procedures, and systems in place to encourage consumers and representatives provide feedback or make complaints. Information supporting consumers and representatives to provide feedback and make complaints was displayed throughout the service.

Consumers and representatives could describe the external complaints mechanisms and advocacy services available to them. Management and staff described how they supported consumers and representatives to access external complaint, language and advocacy services. The service was actively promoting language, external complaints, and advocacy services by providing clear and accessible information to consumers and representatives.

Most consumers and representatives were satisfied with how the service addressed and resolved their concerns and used open disclosure. Some consumers and representatives said their complaints were not always actioned in a timely manner and records showed some historic complaints had not been recorded on the complaints register promptly. Management and staff could describe the underlying principles of open disclosure and how they used it when resolving concerns. Documented complaints and the Continuous Improvement Plan showed appropriate action was taken in response to complaints and open disclosure was practiced. The service had written policies and procedures related to complaints management and open disclosure.

Consumers and representatives expressed satisfaction with the service’s feedback and complaints process, including how they were reviewed and used to improve the quality of care and services. Management and staff described the system for reviewing feedback and complaints and using them to identify continuous improvement opportunities. The Continuous Improvement Plan and consumer meeting minutes confirmed feedback and complaints were reviewed and used to improve the care and 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 7(3)(a) was Not Met. While management described how the workforce was planned to meet the needs of consumers, the Site Audit found there were an insufficient number of staff to deliver safe and quality care and services. Evidence brought forward included:

* Most consumers and representatives interviewed said there were not enough staff in the service. However, only 2 consumers/representatives could identify adverse impacts due to a lack of staff numbers.
* Management described workforce planning strategies such as filling unplanned leave and ongoing recruitment strategies to ensure consumers’ needs were met and meet legislative requirements with the support of the organisation’s human resources department.
* Most staff interviewed said there were not enough staff, particularly on the weekends, and they were sometimes rushed, or unable to provide care in a timely manner.
* Call bell response times were monitored regularly and any outliers to the service’s expected response time of 10 minutes were investigated. The average response time for the previous fortnight was around 2.5 minutes.
* Staff were observed responding to call bells promptly and did not appear to be rushed when providing care to consumers.
* The roster for the previous fortnight indicated unplanned absences resulted in 20 out of 227 shifts being unfilled.
* Several complaints in the service’s feedback and complaints register attributed insufficient staffing as a contributing factor to the issue.
* Management confirmed they had already identified staffing as an issue and initiated various continuous improvement plan actions, including the active ongoing recruitment of additional staff. Management provided evidence that 2 new care staff had been recruited and recruitment for 4 additional staff was underway.

The provider’s response received 8 March 2024, provided additional information and evidence in relation to the ongoing planning and adequacy of the workforce. The provider advised:

* Records showed the service filled most shifts vacated by unplanned leave and agency staff were used to ensure no unfilled shifts.
* An organisational wide review of staffing has been conducted to ensure the service meets the expectations of consumers and delivers quality care and services.
* The master roster has been adjusted to better service the needs of consumers and provide adequate clinical oversight. A trial of these changes is now underway.
* The service is actively recruiting under their recruitment strategy for 2024.
* The lifestyle team has been provided additional resources and the activities calendar has been amended to ensure outings are occurring weekly.

I acknowledge most consumers and staff interviewed felt there were insufficient staff however, there was minimal evidence brought forward of adverse impacts to consumers. I further note the service had self-identified the issue of staffing adequacy and had already initiated corrective actions which included the recruitment of more staff. Given the provider’s improvement actions taken before and since the site audit, I am satisfied the service recognises the importance of having a planned and sufficient workforce and has taken appropriate action, which is ongoing. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(a) Compliant.

I am satisfied the remaining 4 Requirements in Standard 7 are Compliant.

Consumers and representatives said staff were kind, caring, and always gentle when providing care and services. Staff were always observed interacting with consumers in a positive, caring, and respectful manner. The service had various policies, procedures and guidance to ensure staff were kind, caring, and respectful towards consumers.

Consumers and representatives said staff were competent and performed their duties effectively. Management described how the recruitment process ensured staff were competent and had the qualifications and knowledge to perform their roles. Staff described their responsibilities and the competencies and qualifications set out in their documented position descriptions. Workforce records showed staff were recruited against documented job requirements and the necessary security and registration checks were completed.

Consumers and representatives said staff were well trained and had the knowledge and skills to meet consumers’ needs, goals and preferences. Management described how they supported and trained staff to perform their roles in line with the Quality Standards. Staff confirmed the service provided the necessary training and support to enable them to provide quality care and services. Training resources and records demonstrated staff were trained and supported to deliver the outcomes required by the Quality Standards.

Management explained how the performance of each member of the workforce was assessed, monitored and reviewed. Management described the formal annual performance appraisal process, continuous informal monitoring and review, and ad-hoc performance management. Staff said they were supported by management during performance reviews and provided with opportunities for improvement. Records showed staff performance was regularly monitored and reviewed in line with the service’s policy.

# 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 8(3)(c) was Not Met. The Site Audit found the service did not demonstrate effective organisation wide governance systems in relation to regulatory compliance, workforce governance and feedback and complaints. Evidence brought forward included:

* Gaps were identified in relation to regulatory compliance due to multiple consumers not being correctly documented for restrictive practices, workforce governance due to feedback regarding insufficient staffing, feedback and complaints and information management due to complaints and incidents not being promptly lodged in the service’s risk management system. (Refer to Requirement 6(3)(c))
* Most consumers and representatives interviewed said there were too few staff, however only 2 identified adverse impacts they attributed to insufficient staff. (Refer to Requirement 7(3)(a))
* Most staff interviewed said there were not enough staff, particularly on the weekend, and they said this means they are sometimes rushed, or unable to provide care in a timely manner. (Refer to Requirement 7(3)(a))
* Management and staff described effective organisation-wide governance systems in place related to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The provider’s response received 8 March 2024, provided additional clarifying information and evidence in relation to the efficacy of the organisation’s governance systems. The provider advised:

* In late 2023, the long-term facility manager left the service and a comprehensive internal audit was conducted against the Quality Standards. A number of improvement opportunities were identified, and an improvement plan was developed, consulted upon and implemented.
* The improvement plan included full clinical review of all residents commencing with those with identified high impact high prevalence risks and potentially subject to restrictive practices.
* A full review of the roster was undertaken and there has been an increase in staffing with further ongoing recruitment.
* The implementation of the improvement plan is being monitored by the relevant organisation executive in accordance with their governance arrangements.

I note the Site Audit identified some gaps in relation to documenting restrictive practices, staffing sufficiency and recording of complaints and incidents. I have considered these issues further under the relevant Requirement. The evidence brought forward is not indicative of a failure of governance at the organisational level. The effectiveness of the organisation’s governance systems is demonstrated by self-identifying the potential gaps and implementing planned improvement actions, which are well advanced. Given the provider’s improvement actions taken during and since the site audit, I am satisfied the organisation wide governance systems are effective across the required areas. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(c) Compliant.

The Assessment Team recommended Requirement 8(3)(e) was Not Met. The Site Audit found the service had a clinical governance framework with documented policies addressing antimicrobial stewardship and open disclosure. However, the Site Audit found the service did not demonstrate a proper understanding and application of their restrictive practice policies, particularly in relation to chemical and mechanical restraint. Evidence brought forward included:

* Management was unable to correctly identify the number of consumers subject to restrictive practices at the entry meeting.
* Some consumers subject to forms of restraint did not have the required care documentation, completed consents or Behaviour Support Plans, where applicable.
* Management demonstrated they had already raised a continuous improvement plan to audit all consumers for restrictive practices by 2 February 2024.
* The improvement plan includes a review of psychotropic medication usage and ensuring regulatory compliance for all use of restraint, such as having documented Behaviour Support Plans and informed consent.

The provider’s response received 8 March 2024, provided additional clarifying information and evidence in relation the organisation’s clinical governance framework and documented policies and procedures related to minimising the use of restraint. The provider advised:

* The service was already implementing an improvement plan which included commissioning multiple clinical positions and reviewing a range of clinical care issues including the use of restraint and psychotropic medications.
* The established governance structures continue to monitor the progress of the improvement plan and compliance with policies.
* The organisation’s clinical governance framework includes comprehensive documented policies, procedures and registers related to minimising the use of restraint.
* Additional staff education in relation to restrictive practices has been scheduled.

While the Site Audit identified gaps in the documentation of restrictive practices the service’s recently installed management had self-identified the gaps and initiated various continuous improvement actions to address them. The organisation has a documented clinical governance framework which included comprehensive policies, procedures and registers addressing antimicrobial stewardship, minimising the use of restraint and open disclosure. Given the provider’s improvement actions taken during and since the site audit, I am satisfied the organisations documented clinical governance framework is being implemented and monitored for efficacy across all required areas. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(e) Compliant.

I am satisfied the remaining 3 Requirements in Standard 8 are Compliant.

Consumers and representatives said the service was well run and they were actively involved in the development, delivery and evaluation of care and services. Management described a variety of mechanisms in place to encourage consumers and representatives to provide input into the development, delivery and evaluation of care and services. Documentation such as meeting minutes, feedback and complaints records and care plans confirmed consumers and their representatives were engaged in the development and evaluation of care and services.

Management detailed how the organisation’s governing body (the Board) supported the delivery of safe, inclusive, and quality care and services. Management described how the Board monitored the performance of the service through a variety of mechanisms and accountable for ensuring the Quality Standards were met. Documentation confirmed the Board actively oversighted the performance of the service and was accountable for promoting a culture of safe, inclusive and quality care and services, and compliance with the Quality Standards.

Management detailed mostly effective risk management systems and practices which included management of high-impact or high-prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents using an incident management system. The Site Audit identified potential gaps in the recording of incidents as 2 representatives described previous incidents which did not appear in the service’s incident management system. Management provided evidence of a Continuous Improvement Plan action raised prior to the site audit on 27 December 2023, regarding reporting and escalation of incidents. The incidents were lodged in the service’s incident and feedback register on 30 January 2024.

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