Performance

Report

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| Name: | Anzac Lodge Private Nursing Home |
| Commission ID: | 4533 |
| Address: | 2-12 Anzac Avenue, COBURG NORTH, Victoria, 3058 |
| Activity type: | Site Audit |
| Activity date: | 21 February 2024 to 23 February 2024 |
| Performance report date: | 28 March 2024 |
| Service included in this assessment: | Provider: 2552 Java Dale Pty Ltd  Service: 3043 Anzac Lodge 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 Anzac Lodge Private Nursing Home (**the service**) has been prepared by Katherine Richards, 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 consumers, representatives, staff, management, and others; and
* the provider’s response to the Assessment Team’s report received 25 March 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

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

Consumers and representatives said staff treat consumers with dignity and respect and understood their identity and backgrounds. Staff explained how they ensured consumers were treated with kindness, respect, and patience, and this was observed within interactions. Care planning documentation included information to enable understanding of consumers’ identity and diversity.

Policies and procedures were in place to support delivery of inclusive and culturally safe care. Consumers said their culture, beliefs, and values were respected and they were supported to participate in culturally significant activities and events. Staff outlined how assessment processes identified cultural needs and were used to develop supports, including activities to connect with other consumers with similar backgrounds.

Consumers described how they were supported to make and communicate decisions about their care, including who was involved. Staff explained how they offered choices, respected decisions, and took actions to support existing relationships and foster new friendships. Care planning documentation reflected consumer choices and preferences and identified relationships of importance and how these should be supported.

Staff explained processes in place to support consumers take risks, including undertaking a risk assessment and discussing the positive and negative impacts with consumers and/or representatives. Care planning documentation identified risks of choice and strategies, in line with policies, procedures, and feedback. Consumers and representatives said consumers were enabled to undertake activities with risks and mitigating strategies explained.

Consumers reported information provided to support choice was communicated in a manner which was accurate and timely, such as through meetings or calendars. Staff explained how they adapted communication to meet consumers’ needs, learning key words or using communication booklets or translators for consumers who did not speak English. Displayed information informed consumers of activities, with calendars available in Italian and English.

Consumers reported their privacy was respected. Staff explained processes in place to protect consumers’ privacy and confidentiality, including ensuring doors and curtains were closed during cares. Policies and procedures informed staff actions, including relating to the collection and use of personal information and systems to protect confidentiality.

# 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

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

The Assessment Team recommended Requirement 2(3)(a) Not Met, as assessment and planning processes had not identified whether consumers were subject to environmental restraint through the application of a coded keypad at the entrance door, and staff were unaware this might constitute a restrictive practice. Whilst dexterity and cognitive assessments had been undertaken, this was not linked to capacity to use the keycode to exit the service independently. Consequently, the Assessment Team reported the service had not developed the required documentation for restrictive practice for all affected consumers, such as, assessments, consents, behaviour support plans with strategies.

One consumer had an alert device due to prior absconding incidents, and whilst consent from the substitute decision maker had been obtained, and a behaviour support plan developed, a signed environmental restraint form had not been completed until identified at time of the Site Audit. Furthermore, not all consumers prescribed psychotropic medication for administration in response to changed behaviours had been assessed to identify this as chemical restraint.

Management advised that consumers who did not exhibit exit seeking behaviours were not considered to be environmentally restrained, and staff could facilitate movement, and the psychotropic medications were not considered chemical restraint as consumers had relevant diagnoses. Clinical staff said they last received training on restrictive practices over 2 years prior to the Site Audit, and care staff said they had not received any training. The Restrictive Practices policy did not detail systems and processes to manage or minimise use of restrictive practices other than for chemical restraint.

The provider’s response refutes the finding of Not Met, stating they do not view the keypad as constituting environmental restraint for consumers, as the intention is for safety rather than to restrict free movement. Furthermore, consumers identified as being subject to chemical restraint had psychotropic medications prescribed for underlying mental health conditions rather than to support behaviours.

In relation to the secured front door, the provider acknowledges that whilst it may hinder some consumers from freely entering or exiting the service without staff assistance, they did not consider this to necessarily constitute environmental restraint. Insight has been provided on how this position had been informed, including but not limited to, review of information from the Department of Health and Aged Care, National Disability Insurance Scheme, publications, public education sessions, and legal interpretation. The provider argues the availability of the keycode, which is visible and able to be provided to consumers, along with support from staff to open doors does not constitute restriction of free movement or reflect application of environmental restraint. The provider also outlined improvement actions being explored, including implementation of a swipe card or device for consumers unable to use the key code, and including consideration within assessments of the need for alternates to the keypad use to enter or exit.

For the identified consumers prescribed psychotropic medications, the provider states these medications were for the purpose of management of diagnosed mental health conditions rather than chemical restraint. Further reviews have been undertaken, and the medication ceased for 2 of the consumers, as it was no longer required. The provider’s response reflects circumstances where the administration of these medications would be considered chemical restraint, in line with their policy and legislation.

I acknowledge the provider’s response and improvement actions developed. I have considered feedback relating to training within my decision in Standard 7 Human resources, and information within the Restrictive practices policy has been used to inform my decision in Standard 8 Organisational governance.

The service demonstrated awareness of legislative requirements for use of restrictive practices, such as obtaining consent and developing behaviour support plans to minimise use of restrictive practices through application of tailored strategies, reflected within the Site Audit report. Staff were aware of assessment and planning processes, with clinical staff clear on how assessment and planning processes identified restrictive practices and develop strategies to minimise use. The provider has identified potential for improvement within assessment and planning processes to better understand consumer needs and support free movement, demonstrating commitment to best practice processes.

For the consumer with the wandering alert, in coming to my finding of compliance I have placed weight on the consumer having appropriate assessments, including consent and development of a behaviour support plan, and the representative confirmed consultation on the management strategy and consent. The use of a signed environmental restraint form may be required within the organisational process, however, the provider had met legislated obligations for application of environmental restraint if this was the purpose of the device.

In relation to the consumers prescribed psychotropic medication, I have insufficient evidence to demonstrate whether the psychotropic medications prescribed for consumers were or were not being used as chemical restraint. Two of the consumers had not required medication for some time, resulting in the medication being deprescribed during or after the Site Audit. Therefore, in coming to my finding, I have placed weight on comments from the representatives confirming they had provided consent for use, the use of assessment and planning processes to develop tailored behaviour support plans, with staff awareness of non-pharmacological strategies deployed to ensure medication was used as a last resort. Accordingly, I consider the provider has met obligations for use as chemical restraint, if required, with effective assessment and planning processes to understand risk and inform care.

For these reasons, I find Requirement 2(3)(a) compliant.

I am satisfied the other Requirements in this Standard are compliant.

Consumers said staff regularly consult with them on needs, goals, preferences, and end-of-life wishes. Clinical staff outlined approaches to identifying and understanding needs, goals, and preferences, with approach to discussing and reviewing end-of-life wishes. Care planning documentation reflected current needs, goals, and preferences of consumers and included advance care plans and end-of-life care wishes.

Consumers and representatives explained their ongoing involvement in assessment and planning processes, and this was reflected in care planning documentation. Staff described involvement of consumers, representatives, and relevant members of the multidisciplinary team through consultation, assessment, and planning processes.

Staff said they routinely offer copies of updated care and services plans to consumers and/or representatives, however, most were satisfied with verbal updates. Consumers and representatives said they received regular updates and know they could receive copies of the care and services plan.

Care planning documentation demonstrated reviews were undertaken regularly and following incident or change to consider the effectiveness of management strategies. Consumers and representatives said they were aware of review processes, with staff explaining care and services plans were reviewed and updated regularly to ensure information was reflective of consumers’ current needs.

# 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

This Quality Standard is assessed as compliant as 7 of the 7 Requirements have been assessed as compliant.

Clinical and care staff demonstrated knowledge of consumer’s care needs, outlined in care planning documentation, and described strategies used and evaluated to meet these needs. Care documentation of consumers sampled reflected care is safe, effective, and tailored to the needs of consumers. Best practice was demonstrated through staff training and understanding, engagement of specialist practitioners for advice, and available policies and procedures.

Consumers and representatives said risks were understood and well managed. Management explained how assessment and monitoring processes were used to identify risks, along with incident investigations, and high risks were outlined within care planning documentation.

Staff explained processes to identify and support end-of-life care, ensuring consideration of end-of-life wishes and providing emotional care of the family. Care planning documentation for consumers receiving palliative care reflected focus on comfort, including pain management, nutrition, and hygiene care. The Palliative care policy informed identification and management of symptoms along with psychosocial support.

Consumers and representatives said changes in health were promptly recognised and appropriately responded to. Staff explained how they monitored for change, escalating acute changes for review by the Medical officer or through transfer to hospital. Care planning documentation outlined changes to consumer condition and measures taken.

Consumers and representatives said consumer care needs and preferences were known by staff. Staff described how information about consumers was communicated, such as through progress notes, handover processes, and pop-up notifications on the electronic care management system. Care planning documentation demonstrated changes in consumer condition, needs, or preferences were recorded.

Clinical staff gave examples of referral processes used to access providers relevant to consumer needs. Care planning documentation demonstrated referrals were made in a timely manner to appropriate providers in line with directives within the Referral policy.

Consumers and representatives described processes to prevent or manage infections, including cleaning processes, use of personal protective equipment, and screening for COVID-19. Staff outlined infection prevention and control actions, including isolation of unwell consumers, use of personal protective equipment, testing for illness, and commencing antimicrobials appropriate to the infection. Whilst concerns were raised relating to deficits in staff knowledge of antimicrobial stewardship, evidence shows this primarily applied to care staff, and I consider this reasonable given the responsibility for antimicrobial use rests with clinical and medical staff. Supportive documentation included policies, procedures, and an outbreak management plan, with an Infection prevention and control lead to provide specialised guidance for infection control and management.

# 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

This Quality Standard is assessed as compliant as 7 of the 7 Requirements have been assessed as compliant.

Staff explained consumers’ needs and preferences were captured through assessment and planning processes to tailor services and supports, and this was reflected within care planning documentation. Representatives said services and supports for consumers enabled independence and well-being, supporting goals and needs.

Consumers described how their emotional and spiritual needs were met through staff interactions and organised religious services. Staff outlined how they would identify and respond to a consumer’s low mood, including spending additional time or escalating concerns. Care planning documentation included spiritual and emotional needs of consumers and detailed supportive strategies.

Consumers were observed undertaking activities and spending time with visitors and other consumers, and said they felt encouraged to do things of interest within and outside the service. Staff explained how they engaged with consumers to understand interests and support relationships. Care planning documentation identified preferred activities, including those within the community outside the service environment.

Consumers said information was effectively shared, and their needs and preferences were known. Staff explained communication channels to ensure timely sharing of information, for example, dietary preferences were confirmed daily and changes to needs were shared in dietary folders, and lifestyle staff received updates from clinical staff and reported back any identified concerns.

Care planning documentation demonstrated consumer needs were recognised and responded to through timely referrals to external services, such as volunteers. Staff explained referral processes and actions to ensure timely response. Consumers said referrals were made in a timely manner and they received appropriate services and supports.

Consumers described provided meals as being of good quality and quantity, with a variety of options and ability to offer suggestions. Management explained actions taken in response to feedback on the temperature of meals served to consumers who dined in their rooms, with evaluation confirming this was effectively resolved. Staff said the rotating menu was tailored to consumer preferences through feedback, and consumers’ choices of meal options recorded each day. Snacks and sandwiches were available between meals.

Staff said equipment was readily available and outlined cleaning and maintenance processes. Consumers described equipment as safe, suitable, and well-maintained, in line with observations.

# 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

This Quality Standard is assessed as compliant as 3 of the 3 Requirements have been assessed as compliant.

Consumers said they felt a sense of belonging, enhanced by the sense of community, and were supported to style and decorate their rooms. Staff outlined how the environment supported consumer independent movement through wide and level corridors, with a lift to move between floors. Consumers were observed undertaking group activities in larger communal areas, with indoor and outdoor areas available for quieter interaction.

Consumers said they could freely mobilise through the service and were observed using outdoor areas. Staff described cleaning processes, and logs demonstrated cleaning tasks were scheduled and completed on a daily and weekly basis. The use of a coded keypad was identified as a potential for environmental restraint, however, consumers confirmed they were aware of the code or could seek staff assistance to open the door and enable free movement (further information relating to this has been considered within my findings for Standard 2 Requirement 2(3)(a)).

Consumers and representatives said equipment was clean and well maintained. Staff explained processes for monitoring safety and cleanliness of furniture, fittings, and equipment and actions to remove damaged items and lodge maintenance requests. Furniture, fittings, and equipment were observed to be clean and suitable for use, with service tags reflective of recent testing.

# 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

This Quality Standard is assessed as compliant as 4 of the 4 Requirements have been assessed as compliant.

Consumers and representatives said they felt supported and comfortable to provide feedback and complaints. Staff explained available verbal and written feedback methods and described how they provided encouragement to raise concerns through meeting agenda items. Feedback forms and collection boxes were displayed, and meeting minutes included feedback and complaints as a standing item.

Consumers and representatives reported advocacy groups attended consumer meetings and they could reach out directly to them if concerned. Staff explained how to access interpreter and translation services and were observed using an interpreter when undertaking an assessment. The consumer handbook provided details for external complaint services and advocacy and language services available, and posters on advocacy and complaints services were displayed throughout the service.

Management explained the response process for complaints, ensuring an open disclosure process was used. Documentation within the complaint register demonstrated timely actions taken in line with policies and procedures, including application of an open disclosure process. Consumers and representatives said swift action was taken in response to complaints with resultant satisfactory outcomes.

Documentation demonstrated feedback and complaints had been used to improve services and consumer experience. Management gave examples of identifying trends within complaints, developing improvement activities within the Continuous improvement plan, and evaluating effectiveness with consumers. Consumers said they were kept informed of improvements through discussions within meetings.

# 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)(d) Not Met, as staff training relating to some of the regulatory requirements, such as application of restrictive practices and antimicrobial stewardship, had not been undertaken since 2021 resulting in deficiencies in staff knowledge and explanation of practice. Whilst compliance with mandatory training modules was high, including for infection prevention and control principles, records did not include restrictive practice training. Furthermore, the service could not demonstrate timely provision of responsive training for identified or emerging risks of consumer falls.

The provider’s response refutes the finding of Not Met, pointing out this is contradicted by evidence in other Requirements of the Site Audit report, particularly Requirement 2(3)(a) where staff explained assessment processes and requirements for restrictive practice use. However, the provider does acknowledge formal training has not been provided on restrictive practices since 2021 and has coordinated mandatory education for all clinical staff. The provider states the uncertainty relating to antimicrobial stewardship education could have been clarified through interviewing the Infection prevention and control lead, who had records of training delivered in 2022, following implementation of a new policy, and reminders sent to staff in December 2022 and June 2023, however, the Assessment Team did not wish to speak with this staff member. Furthermore, prompts had been built into the electronic care management system to guide staff on antimicrobial stewardship practices when identifying infections. The provider asserts effectiveness of staff knowledge of antimicrobial stewardship is further evidenced within practices and the absence of identifiable infection trends.

In relation to identifying falls as a high prevalence risk, the provider states was believed to arise from a misunderstanding. Whilst improvements were identified in assessment processes following falls, leading to actions included on the Continuous improvement plan, this was considered a low-risk area, with activities developed and completed, including providing education and embedding prompts within the electronic care management system, over a period of time.

I acknowledge the provider’s response and improvement actions developed. In coming to my decision, I have considered it reasonable for differences in knowledge and understanding between clinical staff and personal care staff, aligned to their roles and responsibilities. Assessment, management, and monitoring processes remain the responsibility of clinical staff and management, rather than care staff, and I consider differences in care staff understanding relating to these topics to be reasonable. The provider has acknowledged the absence of training in relation to restrictive practices since 2021, with actions to remedy this. I would strongly encourage mandatory training programs ensure staff understanding is sufficient to deliver outcomes required by the Quality Standards, including legislated requirements, relevant for their roles. The provider has submitted evidence of information provided to staff on antimicrobial stewardship, and the prompts within the electronic care management system, along with improvement activities to strengthen staff understanding. A copy of the continuous improvement activities in relation to falls assessment processes has demonstrated ongoing activities and monitoring of progress. I have also placed weight on findings of compliance relating to delivery of personal and clinical care within Standard 3 in coming to my decision of compliance.

For these reasons, I find Requirement 7(3)(d) compliant.

I am satisfied the other Requirements are compliant.

Consumers and representatives reported awareness of staffing challenges but said consumer care was never compromised. Management explained how shift vacancies were filled and monitoring undertaken to ensure consumers received prompt assistance and timely care, evidenced by rostering documentation and call bell reports.

Consumers and representatives said workforce interactions were kind, caring, respectful, and recognised culture, identity, and diversity. Staff said they received education on cultural safety, and management said language training was available to interested staff to meet needs of consumers with English as a second language. Staff interactions were observed to be kind and respectful.

Position descriptions outlined responsibilities, accountabilities, qualifications, skills, training, and experience. Management explained how recruitment and monitoring processes ensured staff were competent and suitable for their role. Documentation demonstrated staff held suitable qualifications for their roles, with monitoring of professional registration, certification, mandatory training, and vaccinations.

Staff described monitoring of performance through annual performance assessment reviews, explaining involvement of self-assessment and review with management. Management acknowledged the completion of formal reviews was lower than desirable, with improvement activities developed, but explained the formal process was supported through monitoring of training, meeting attendance, and supervisor feedback.

# 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 Requirements 8(3)(c) and 8(3)(e) Not Met.

Evidence brought forward in Requirement 8(3)(c) and 8(3)(e) related to deficiencies in staff training and knowledge of antimicrobial stewardship and restrictive practices, linking these findings to deficiencies in workforce governance, regulatory compliance, and clinical governance. Furthermore, the Restrictive practices policy did not detail systems to minimise use of restrictive practices outside of chemical restraint.

The provider’s response refutes findings related to staff knowledge of these practices, as outlined in Standard 7 Requirement 7(3)(d), providing evidence of training and acknowledging absence of restrictive practices training since 2021 with actions to remedy this. Further evidence to demonstrate effectiveness of governance processes included high completion rate of assessments for antimicrobial stewardship application, the absence of identifiable infection trends, and education of Medical officers to inform best practice prescribing of antimicrobial medications. Further actions to strengthen antimicrobial stewardship included regular reminders within infection prevention and control reports, displaying educational information within each wing, and ongoing training for staff. In relation to restrictive practices, explanation has been provided of assessment processes, policies, and procedures to promote and support independence and autonomy to support understanding of environmental restraint. The provider states they are confident the Restrictive practices policy reflects current regulatory requirements and practices, however, have identified areas for improvement for practices beyond chemical restraint and have commenced processes to review and update guidance material.

I acknowledge the provider’s response and improvement actions developed. The evidence before me does not demonstrate failure of clinical or organisational governance processes to inform and oversee care and workforce actions. The Site Audit report reflects workforce governance frameworks, including policies and procedures, informed recruitment and rostering processes, monitoring of performance, and position descriptions outlined qualifications, experience, and responsibilities. The effectiveness of the framework has been further considered in findings of compliance in all requirements in Standard 7. Regulatory compliance was managed through governance roles and responsibilities, including monitoring legislation and ensuring changes were reflected within policies and procedures and communicated to staff.

The clinical governance framework was outlined within the Clinical governance policy, and informed by policies, procedures, monitoring, and oversight, including through monthly clinical meetings. As evidenced within findings in Standards 2 and 3, staff demonstrated understanding of assessment and planning processes in relation to restrictive practices and used tailored strategies to minimise use of restraint. The provider has taken corrective action to ensure staff are provided training on restrictive practices, but I do not find any evidence within the Site Audit report reflecting specific deficiencies of individual understanding.

I have considered the impact of the secured door restricting free movement, and whether this could be viewed as environmental restraint. As the code to the door was made available to consumers, including through display next to the keypad, I do not consider the intention was to restrict free movement and evidence provided does not demonstrate it was applied a strategy to support changed behaviours.

For the reasons outlined above, I find Requirements 8(3)(c) and 8(3)(e) compliant.

I am satisfied the other Requirements in this Standard are compliant.

Consumers described their engagement in the development, delivery, and evaluation of care through meetings and feedback processes. Management explained other formal and informal engagement processes, such as through the Consumer advisory body, case conferences, surveys, and daily interactions. Documentation, such as meeting minutes, survey results, and feedback forms, confirmed consumer engagement and responsive changes.

Management described the organisational structure, explaining how oversight of service performance is maintained through reporting and benchmarking, with corrective actions taken if areas for improvement are identified. The Board had sought exemptions for the requirement for independent members, but whilst waiting for outcome had commenced recruitment processes, and one of the current Board members held clinical qualifications. Documentation, including meeting minutes for the Board and subcommittees, demonstrated ongoing monitoring to ensure accountability for the delivery of safe, inclusive, and quality care and services.

The risk management framework included processes, policies, procedures, and training to identify and manage risk and investigate and respond to incidents. Monitoring and reporting processes were used to inform the governing body, with minutes from the Quality Governance and Board meetings demonstrating oversight and drive improvements. Whilst the Site Audit report raised concerns relating to responsive education on falls management, the provider’s response demonstrates this was neither reflective of the risks or actions being undertaken. Staff demonstrated awareness of processes to support consumers to live their best lives, including where that involves taking risks. Policies such as the Abuse, unexpected absence and Serious Incident Response Scheme policy informed staff responsibilities to recognise and report elder abuse or neglect, and serious incidents.

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)