Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | BaptistCare Orana Centre |
| Commission ID: | 0618 |
| Address: | 193-201 Brisbane Water Drive, POINT CLARE, New South Wales, 2250 |
| Activity type: | Site Audit |
| Activity date: | 28 November 2023 to 1 December 2023 |
| Performance report date: | 2 February 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 5598 BaptistCare Orana Centre |

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 BaptistCare Orana Centre (**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;
* a Performance Report dated 22 July 2022, following a Site Audit conducted from 24 May 2022 to 27 May 2022; and
* the provider’s response to the assessment team’s report received 10 January 2024.

# Assessment summary

|  |  |
| --- | --- |
| 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

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(e), and 1(3)(f) for Standard 1 Consumer dignity and choice following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

Consumers said they were treated with dignity, and staff respected their identities. Staff receive training on treating consumers with dignity and respect, and demonstrated knowledge of consumer backgrounds, speaking respectfully of and with consumers. Policies and procedures guided staff in working respectfully with consumers of diverse backgrounds.

Consumers and representatives said the service worked with them to better understand cultural backgrounds and interests and respect their backgrounds. Staff demonstrated understanding of cultural needs and preferences of consumers, as outlined within care planning documentation. Assessment and planning processes captured cultural backgrounds and needs, and a cultural register has been developed to assist with development of care and services plans.

Consumers and representatives participated in care conferences, held every 6 months. Consumers said they felt supported to make and communicate decisions about care and who is involved in decision-making. Staff were aware of consumer preferences and explained the importance of regularly checking for changes to these. Care plans recorded consumer choices and key relationships, and detailed who should be involved in decision making or contacted for emergencies.

Consumers explained being supported to live life as they chose and said discussions were held with them about associated risks. Staff explained processes used to support consumers choosing to take risks, including consultation, assessment, and development of mitigating strategies. Training records for staff included education on application of dignity of risk principles including the service’s commitment to supporting consumers exercise their rights to take risks.

Consumers and representatives said they receive sufficient information and updates to make informed decisions. Staff explained how information about activities is provided in writing, with each consumer getting a calendar and activities displayed each day, but also verbally remind consumers when things are starting. Newsletters and consumer meeting minutes were available and displayed on noticeboards. Information on how to make complaints was available in multiple languages and reminders raised as a standing agenda in meetings.

Consumers said staff always respect their privacy and seek permission before entering rooms. Staff described actions taken to respect consumer privacy and ensure confidentiality is maintained, undertaking mandatory training on these topics and receiving reminders in staff meetings. The staff handbook outlines expectations from the Privacy and dignity policy for staff to ensure consumer information remains confidential.

For the reasons outlined above, I find the Service Compliant with Standard 1 Consumer dignity and choice.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in all Requirements for Standard 2 Ongoing assessment and planning with consumers following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

Staff explained assessment and planning processes captured consumer needs and considered risks, and said they were provided extensive training in risk management for consumers. Care planning documentation was tailored to the consumer, containing sufficient information to inform personalised care with management strategies for identified risks. Policies, procedures, and training guided staff, and records were maintained to provide management oversight of assessment completion.

Staff explained ongoing discussions with consumers and representatives to ensure care meets consumer needs, goals, and preferences, and encouragement is provided to discuss advance care planning. Training provided included a ‘see me’ program to consider consumers as individuals and identify personalised needs, goals, and preferences. Care planning documentation outlined needs, goals, and preferences, along with end-of-life wishes if known, and information aligned with consumer and representative feedback.

Consumers and representatives reported regular communication, welcomed the opportunity to partner in care, and were familiar with other providers involved. Care planning documentation reflected involvement of consumers and representatives and input from Medical officers, Allied health providers, and specialised services. Staff explained regular communication processes with consumers and family, such as through case conferences or monthly reviews, and they encourage discussion of concerns.

Consumers and representatives said staff explain consumer care and what is included, including updated management strategies, and a copy of the care and services plan is provided. Staff said they discuss care with consumers and representatives during routine reviews, communicate changes, and provide a copy of the care and services plan. Displayed information on noticeboards reminded consumers and representatives they could request a copy of the care and services plans at any time. Staff were observed to be able to readily access consumer information, including progress notes and care and services plans.

Management and staff explained monitoring processes used to identify change and systems and processes to guide staff evaluation of strategies. Consumers and representatives confirmed care and services are reviewed regularly and following incident or change. Care planning documentation demonstrated ongoing and regular reviews, with scheduled 3 monthly reviews, and incidents triggered evaluation of strategies.

For the reasons outlined above, I find the Service Compliant with Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in all Requirements for Standard 3 Personal care and clinical care following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

Most consumers said they were provided care suitable to their needs and preferences, although one said they did not always receive personal care in a timely manner because of a staff shortage or unfamiliar staff (considered further within my decision for Standard 7 Requirement 7(3)(a)). Staff explained how they tailored care to the individual needs of consumers. Management said staff receive ongoing training to ensure delivery of care that meets best practice standards. Sampled care areas of restrictive practices, changed behaviours, skin integrity and wound care, pain management, medication administration, and management of specialised clinical care demonstrated provision of safe and effective care aligned with best care practice.

Staff demonstrated familiarity with consumers’ risks and management strategies and explained the high-risk case management processes developed. Care planning documentation demonstrated risks were identified with mitigating strategies to inform care. Staff received training on the identification, management, ongoing assessments, and reviews for consumers with identified risks.

Staff explained how they adjusted care for consumers receiving palliative or end-of-life care to manage comfort, reduce pain, and meet emotional and spiritual needs. Documentation for a late consumer demonstrated provision of care respectful of the consumer’s wishes, and involvement of palliative care providers to ensure facilitation of a pain-free and dignified death.

Consumers and representatives said changes are identified and responded to in a timely manner. Staff explained how they identify and assess change in consumer condition, using assessment tools and handover processes, with a multidisciplinary approach to managing changes. Training was provided to staff on identification of deterioration in consumer and appropriate actions, and implementation of a Stop and watch tool.

Consumers and representatives said sufficient information was shared about consumers. Staff explained how information was shared through care and services plans, progress notes, and verbal and written handovers. Staff were observed accessing electronic records of consumers to review and update information. Monitoring of documentation was undertaken to ensure information, such as changed needs, is identified in a timely manner.

Staff described referral processes for a range of providers and external organisations, which was reflected within care planning documentation. Referrals were recorded on a spreadsheet and monitored by management to ensure they were appropriate and timely. Consumers and representatives said they could access other health providers when needed.

Infection control measures were known by staff, who identified key actions such as hand hygiene, monitoring for symptoms, and using personal protective equipment with annual mandatory training undertaken. Management explained the vaccination program for consumers and staff, and processes inform minimisation of antibiotic use through ensuring appropriate use.

For the reasons outlined above, I find the Service Compliant with Standard 3 Personal care and clinical care.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e) and 4(3)(f) for Standard 4 Services and supports for daily living following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance, however, the Assessment Team have recommended 4(3)(a) Not Met.

**Requirement 4(3)(a)**

The Assessment Team recommended this requirement Not Met in relation to insufficiency of staff affecting lifestyle support activities, with some consumers and representatives explaining they were not assisted to attend preferred activities. Lifestyle staff explained different activities programs are offered in each area, and consumers are welcome to attend any of the available activities, however, care staff said at times they are rushed to deliver personal care and did not always have time to take consumers to activities.

The provider has refuted the Assessment Team’s recommendations, stating they believed the views expressed were reflective of the situation some months prior to the Site Audit, with recruitment and rostering strategies being used to ensure lifestyle activities were prioritised and optimised. Changes included increasing lifestyle staff shifts, and including Physiotherapist led wellness activities. The provider acknowledges prior to September 2023, they had identified staff were not prioritising assistance, however, since this time they communicate activities at clinical handover so care staff can ensure consumers are ready and supported to attend, and compliance is monitored by clinical staff and management. In the month prior to the Site Audit, 4 lifestyle shifts were vacant, however, 2 were covered by the Lifestyle coordinator, and although 2 could not be filled, the overall number of lifestyle staff and activities was higher than prior to September 2023.

The provider has undertaken investigation for consumers expressing impact of a lack of assistance to attend activities, including review of activity attendance and preferences within care planning documentation. Where one consumer was identified as not attending preferred activities, an interview as undertaken with the Lifestyle coordinator who explained errors in documentation within the consumer’s electronic records. The provider has submitted improvement activities developed to ensure services and supports to meet consumers’ needs, goals, and preferences, with improvements to written handover processes and monitoring of attendance records and undertaking a review of the Lifestyle program.

I acknowledge the provider’s response and responsive actions. I also acknowledge actions taken in response to the previous findings of non-compliance, with improvements to assessment and planning processes and monitoring through surveys. The evidence of the Assessment Team is primarily positive, with most consumers saying they receive services and supports to meet their needs, and supportive of a finding of compliance. Where consumers raised concerns, there is variation in the frequency of impact, and I am satisfied with the analysis and explanation from the provider for each of the named consumers. The provider has brought forward evidence of improvements made to the lifestyle program and number of lifestyle staff since identifying issues in September 2023, with ongoing actions to ensure services and supports effectively meet consumer’s needs, goals, and preferences.

For these reasons, I find the Service Compliant with Requirement 4(3)(a).

Consumers and representatives explained how staff spent additional time to provide emotional care and respect spiritual and religious needs. Staff described available pastoral care and religious services, with access to online church services, and said they knew consumers well enough to identify low mood and monitor for consumers at risk of isolation to add one-on-one activities. The Stop and watch tool is used by all staff, including during activities, to identify consumer changes or behaviours. Care planning documentation outlined consumers’ emotional and spiritual needs.

Consumers described how they were supported to participate in the community and maintain relationships of importance, including through use of videocalls to participate in groups when they were unwell. Staff explained how they encouraged consumers to participate in group and/or individual activities and continue doing the things they enjoy, facilitating connections with friends and relatives who are not local through videocalls. Care planning documentation outlined relationships of importance, interests, and supportive measures to enable participation.

Consumers and representatives said staff were well informed of consumer needs and preferences. Staff described communication processes to ensure information was effectively shared, for example, kitchen staff are informed of dietary changes by the Care manager with documented needs on a clipboard for quick reference.

Lifestyle staff explained referral processes for external organisations, such as volunteer schemes, and how they identified consumers who would benefit, with consumers made aware of availability through consumer meetings. Consumers said they were connected with appropriate services and supports.

Consumers said meals were suited to needs and preferences, they enjoyed the mealtime experience, were provided choices, and were encouraged to give feedback on the meal. The rotating seasonal menu is developed by an external company to ensure nutritional adequacy, and reviewed consumers who can request alterations or adjustments. Complaints about food are addressed and responded to by kitchen staff, who gave examples of how they adapted matters to meet consumer needs and expectations. In response to consumers saying names on menus were not familiar, changes were made to better describe items, and a photo book of meals was being developed.

Consumers and representatives said equipment, including personal equipment and items used for activities, was clean and well maintained. Staff said they could access equipment when needed, and monitoring processes were used to ensure safety. Equipment was observed to be clean, well maintained, and in sufficient supply.

For the reasons outlined above, I find the Service Compliant with Standard 4 Services and supports for daily living.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in Standard 5 Organisation’s service environment in relation to Requirement 5(3)(b) following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance and is now compliant with this Requirement.

Consumers explained how they were supported to feel at home, personalising rooms and being involved in decorating the service for Christmas. Management said they consider the service to be the home of consumers and encourage consumers to contribute in ways that align with their interests, such as decorating or watering plants. Features within the environment, such as signage, handrails, spacious corridors, and level flooring, enabled consumers to independently move through the service.

Consumers and representatives said they can move freely through different areas, and the environment was clean, and any reported problems were quickly responded to. Staff described processes in place to maintain cleanliness of the service environment, with daily and weekly cleaning duties logged. Maintenance staff and management completed audits to monitor the environment. Consumers were observed moving through indoor and outdoor areas of the service.

Staff were able to describe processes to report maintenance issues, with items captured in the maintenance log demonstrating preventative and responsive maintenance actions were addressed in a timely manner. Consumers said furniture and equipment was safe and checked regularly. Furniture, fittings, and equipment were observed to be clean and in good working order, and, where applicable, equipment had service tags in date.

For the reasons outlined above, I find the Service Compliant with Standard 5 Organisation’s service environment.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in Standard 6 Feedback and complaints in relation to Requirements 6(3)(b), 6(3)(c), and 6(3)(d) following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

Consumers and representatives said they felt comfortable to provide feedback or make complaints. Management described available feedback avenues, including feedback forms, speaking with staff or management, raising through consumer meetings or focus groups, or emailing the provider. Staff said where complaints are raised, they would listen and rectify the issue or escalate to management if further assistance is required. Feedback forms were readily available throughout the service, along with feedback boxes for submission, and meeting minutes demonstrated feedback and complaints are a regular agenda item.

Consumers said they are aware of advocacy services, and external complaint pathways. Management and clinical staff were aware of how to access advocacy and interpreter services, and ensure consumers and representatives are informed of the services through the Resident handbook and within consumer meetings. Displayed information informed consumers and representatives of advocacy groups, interpreter services, and external complaint pathways with information available in multiple languages.

Consumers and representatives reported satisfaction with management’s responses to complaints. Staff and management were aware of responsibilities within complaint management policies and procedures, including application of open disclosure. Feedback captured in the register demonstrated use of open disclosure including apology, investigation, explanation, and resolution of complaints. Staff undertake mandatory and refresher training on feedback, complaints, and use of open disclosure.

Management and staff described changes made in response to consumer feedback, and consumers verified the improvements and provided examples. Monthly audits of complaints are conducted by the organisation to identify trends, and ensure complaints are addressed. Documentation demonstrated feedback was active sought, recorded, used to inform actions captured in the Continuous improvement plan, with monitoring of outcomes.

For the reasons outlined above, I find the Service Compliant with Standard 6 Feedback and complaints.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e) for Standard 7 Human resources following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance, however, the Assessment Team have recommended 7(3)(a) Not Met.

**Requirement 7(3)(a)**

The Assessment Team recommended this requirement Not Met in relation to insufficiency of staff. Consumers and representatives said there were not enough staff impacting on timeliness of personal care delivery, access to lifestyle activities, or delays with meals. Staff said the service cannot always fill shifts, especially for unplanned leave, which impacts on ability to provide timely care, especially when consumers need assistance of more than one staff member. Staff reported feeling rushed during care provision, and when asked to assist the kitchen for meals they were not able to assist consumers needing help or supervision to eat. Rostering for a sampled period demonstrated some shifts could not be filled. Management acknowledged challenges relating to staffing, sharing communication with staff to seek feedback and inform recruitment activities, however, were unaware of dissatisfaction of consumers and representatives.

The provider has refuted the Assessment Team’s recommendations, stating the evidence is inconsistent, for example, comments that management were not capturing feedback is contradicted by findings within Standard 6, and the number of consumers reporting impact is contradictory within differing areas of the report. The provider believes the issues and examples raised by consumers, representatives, and staff are historical, acknowledging past issues but explaining since September 2023 recruitment and rostering have been improved, and this was further enhanced in November 2023. Staffing hours have been increased and, where possible, staff are not moved between areas unless as a short-term replacement, and staff, consumers, and representatives kept informed of changes to these processes. Where staff have assisted with meals, shifts have been extended to ensure care hours were maintained. The provider also states the report did not consider all information provided to the Assessment Team, including but not limited to evidence of weekly meetings about recruitment, rostering tools to ensure consumer needs and care minutes were met, and monitoring of clinical indicators and feedback demonstrating ongoing improvements in consumer care outcomes.

Other supportive information from the provider included analysis of rosters for the month prior to the Site Audit identifying 19 other instances of unplanned leave, with demonstrating shortfalls were covered. The 4 unfilled shifts, of which one was an administration staff member, represented 0.7% of total number of shifts during the month. Continuous improvement plans demonstrate ongoing recruitment efforts and monitoring of the workforce number and mix, with strengthening of current approaches through refresher training to the Roster coordinator and reminders to clinical staff on filling vacant shifts.

I acknowledge the provider’s response and responsive actions. Consideration has also been given to evidence within other Standards, demonstrating provision of safe and effective consumer care. Whilst the feedback from consumers, representatives, and staff includes some impact on consumers, there is no information the frequency of occurrence nor evidence of ongoing impact to consumer safety or well-being. The Assessment Team brought forward examples from 8 consumers, most of whom said they were ‘sometimes’ impacted, with one saying they ‘regularly’ waited for assistance during meals. The provider has acknowledged challenges in staffing, in line with those throughout the aged care sector, and demonstrated ongoing efforts to recruit and retain staff. Rostering processes ensure the workforce is planned with consideration of skills, as well as numbers and mix to ensure consumer needs are met and safe and quality care provided. Whilst I would encourage the Service to ensure processes ensure consumer assistance and safety is prioritised where care staff are utilised to cover shortages for the kitchen, the Service has demonstrated shifts are filled, and unplanned leave covered with few exceptions.

For these reasons, I find the Service Compliant with Requirement 7(3)(a).

Consumers and representatives said staff interactions were kind and respectful, aligning with observations. Staff gave examples of how they ensured care was respectful of consumer diversity and said they would report any observed behaviour that did not meet expectations.

Consumers and representatives stated staff were competent and knew how to perform their roles. Management explained processes to ensure staff are qualified and competent, with documentation demonstrating oversight of compliance with mandatory checks, such as police clearances. Staff said expectations of their role were communicated, with position descriptions and duties provided at time of employment and updated with changes of expectations.

Staff described available training and additional supports available, with expectations of ongoing learning. The service has a dedicated Quality education supervisor who has reviewed and enhanced training programs to ensure appropriate onboarding of staff and identify training needs for development of ongoing programs. Training records were reviewed weekly to ensure compliance, and demonstrated all current staff were up to date with requirements.

Staff and management described performance appraisal and monitoring processes and frequency. Management explained how they ensured scheduled reviews were completed through differing departments, with monitoring of electronic records. Informal staff check-ins were also undertaken with new staff, with plans to include this on a more formal basis. Documentation demonstrated appropriate actions were taken in response to underperformance or complaints.

For the reasons outlined above, I find the Service Compliant with Standard 7 Human resources.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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 non-compliant in all Requirements for Standard 8 Organisational governance following a site audit in May 2022. Evidence in the Site Audit report dated 28 November 2023 to 1 December 2023 supports that the Service has implemented improvements to address the non-compliance, however, the Assessment Team have recommended 8(3)(c) Not Met.

**Requirement 8(3)(c)**

The Assessment Team recommended this requirement Not Met in relation to insufficiency of staffing, identified in Standard 7 Requirement 7(3)(a). Evidence brought forward demonstrates ongoing recruitment and workforce planning, and awareness of organisational management and the governing body, consultation with staff regarding needs. Processes were in place to ensure workforce qualifications, competency, and skills. However, the Assessment Team stated the impact on consumers due to staffing levels and unfilled shifts demonstrated insufficient organisational response. The Assessment Team was satisfied with governance systems relating to information management, continuous improvement, financial governance, and regulatory compliance.

The provider’s response refutes the Assessment Team’s findings, acknowledging difficulties in recruitment due to a national shortage of staff, however, bringing forward evidence of responsive strategies. Evidence of improvements in staffing levels has been brought forward, with successful recruitment of a significant number of staff, and the organisation has implemented innovative retention programs. Additional resources have also been included at organisational level to assist with recruitment and retention. The rostering platform has been upgraded, and additional staff recruited for analytics and rostering support. A continuous improvement activity has been created with actions to ensure effective workforce governance.

I acknowledge the provider’s response and actions. In coming to my decision, I have also considered evidence on financial governance processes brought forward by the Assessment Team, demonstrating approval for increase in staffing numbers and recruitment. Furthermore, the Site Audit report demonstrates compliance with regulatory requirements, including employment of a qualified Infection prevention and control lead and meeting legislated nursing hours and consumer care minutes.

The evidence before me demonstrates the presence of effective organisational governance systems for key operational areas, including workforce planning. Although management were unaware of the extent of the reported impact on consumers, difficulties in recruitment and retention of the workforce are acknowledged, along with efforts to address this and I find this does not represent deficiencies within the governance framework or lack of organisational actions.

For these reasons, I find the Service Compliant with Requirement 8(3)(c).

Consumers described methods to engage in the development, delivery, and evaluation of care, including through feedback pathways, participating in consumer meetings, or joining the Consumer advisory group which commenced in October 2023. Management explained how they encouraged consumer participation, with efforts to increase involvement in the evaluation and design of services. A Food forum was introduced in October 2023, following an identified trend in complaints about food, with demonstrated improvement actions and outcomes.

Management described the organisational structure, including the regional teams, committees, and governing body, and reporting and escalation pathways. Board meeting minutes demonstrated review and discussion of updates, including clinical and care reports, incidents, and feedback. Management said the Board provides regular updates, ensures trends and concerns are identified, investigated, and improved, and is responsible for ensuring policies and procedures are updated to align with best practice and regulatory requirements. Key responsibilities for each level of management and the Board are outlined to ensure promotion of safe practices and care.

Staff and management described processes for reporting and responding to incidents, including responsibilities under the Serious Incident Response Scheme. The risk management framework, consisting of policies, procedures, and training, guided staff in identifying and responding to existing and potential risks. Management explained the new incident reporting tool, and the service analyses clinical data to identify trends and areas for improvement. Clinical risks are discussed at handover and within weekly management meetings. Processes were in place to enable consumers to live their best lives, including supports for undertaking activities with risks.

The Care and clinical governance framework consisted of policies, procedures, and training to guide staff with monitoring by clinical management. Antimicrobial stewardship processes were known by staff, overseen by the Infection prevention and control leads, monitored within Leadership meetings and the Medication advisory committee, and analysis of outbreaks undertaken to evaluate learnings and guide improvement. Policies, procedures, and training informed staff of appropriate use of restrictive practices, with further education coordinated to ensure the service minimises use. Staff said they received training in use of open disclosure, and the use was reflected within complaints management processes.

For the reasons outlined above, I find the Service Compliant with Standard 8 Organisational governance.

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)