Performance

Report

**1800 951 822**

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| Name: | Barrington Lodge |
| Commission ID: | 8031 |
| Address: | 120 Swanston Street, NEW TOWN, Tasmania, 7008 |
| Activity type: | Site Audit |
| Activity date: | 14 May 2024 to 16 May 2024 |
| Performance report date: | 11 June 2024 |
| Service included in this assessment: | Provider: 1671 The Salvation Army (Tasmania) Property Trust  Service: 5004 Barrington Lodge |

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 Barrington Lodge (**the service**) has been prepared by N Eastwood, 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 7 June 2024.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

**Standard 2**

* Requirement 2(3)(e) ensure systems are implemented to support regular review of consumer care needs

**Standard 3**

* Requirement 3(3)(a) ensure care needs are met including complex care needs such as wound management and where deterioration or progression to end of life care occurs
* Requirement 3(3)(b) investigate, review and finalise clinical incidents to ensure analysis prevention of recurrence occurs
* Requirement 3(3)(g) implement and monitor effective antimicrobial stewardship measures

**Standard 4**

* Requirement 4(3)(c) implement and evaluate a meaning lifestyle program

**Standard 6**

* Requirement 6(3)(c) record feedback and complaints ensuring actions are taken including consideration to open disclosure
* Requirement 6(3)(d) monitor and analyse feedback and complaints for trending and areas for improvement

**Standard 7**

* Requirement 7(3)(c) monitor staff compliance with qualifications and knowledge
* Requirement 7(3)(d) implement and sustain adequate staff training and education systems
* Requirement 7(3)(e) maintain ongoing staff performance monitoring

**Standard 8**

* Requirement 8(3)(c) ensure feedback, complaints, legislative and regulatory compliance is maintained with adequate governance and oversight to inform continuous improvement
* Requirement 8(3)(d) maintain adequate clinical oversight to support identification and management of risk in high impact high prevalence areas
* Requirement 8(3)(e) implement and sustain principles of open disclosure and antimicrobial stewardship

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Consumers and representatives were satisfied staff are respectful, treat them as individuals and support cultural needs and preferences. Consumer accounts supported an individualised approach with respect to religious and personal beliefs as well as consistent documentation reflecting these considerations.

The service demonstrated shared respect, shared meaning, and shared knowledge about culturally safe practices by knowing each consumer’s story and preferences. Consumers said they are supported and encouraged to participate in their religious and spiritual practices, identify their cultural preferences and other significant needs.

Staff explained care plans are regularly reviewed with choices and preferences updated as they occur. Staff also indicated it is important to be flexible in their work schedule as consumers may change their mind on the day about the timing of personal care and room cleaning depending on how they are feeling.

Where risks to a consumer’s health and wellbeing have been identified, the risks are assessed and documented in consumer care planning documents. Staff discussed encouraging consumers to live their best life and how the service approaches risk management by providing support and guidance to meet each consumer’s needs. There was evidence of consideration to consumers who smoke as well as where consumption of alcohol occurs, appropriate individualised risk and safety assessments are in place.

The service provides a range of communication methods including a monthly newsletter, resident handbook, lifestyle activities calendar, weekly menu, resident and representative meetings, and food focus group meetings. Staff demonstrated an understanding of maintaining confidentiality and described how consumer information is protected.

The Approved Provider submitted a response with additional information related to Requirements 1(3)(a) and 1(3)(d) and consumers identified in the Site Audit report. The service has implemented additional support strategies for consumers as a result of assessments and staff training. I note the Site Audit report reflects that there is no current method of communication between the outside smoking area and staff, I encourage the service to consider implementing processes to enable communication.

# 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)I | 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirement 2(3)(e) and as a result does not comply with Standard 2.

Requirement 2(3)(e):

Care documentation did not reflect reviews in line with the service’s process. Consumer care reviews were observed to be overdue and not actioned when a change or an incident had occurred. Clinical staff said they review care files according to the electronic scheduled review, however, when consumers’ condition changed, assessments had not been updated in a timely manner.

The Approved Provider submitted a response (the response) with additional evidence and supporting Plan for Continuous Improvement (PCI). The response refers to actions under connected Requirement 3(3)(a) and reflects further information and implementation of immediate actions and referrals to address deficits identified with outstanding assessments and reviews for identified consumers. The service has a plan for additional education to improve clinical assessment and plans post changed care needs and the PCI reflects care planning documentation and case conferencing improvement goals to be achieved. I acknowledge the service's challenges with senior management staffing and note there is now a full leadership team to ensure the progression toward ensuring compliance with this Requirement. With consideration to the available information and response, I consider further time is required to ensure improvements are successfully implemented and sustained in practice. As a result, I find this Requirement is non-compliant.

Compliance with remaining requirements:

Consumers and representatives indicated staff generally plan care that is right for them and meets consumer health and care needs. Staff described the assessment and care planning process that is prompted on the electronic care document system and covers a range of validated assessments. A review of care documentation reflected staff identify risks to consumer health and plan for effective care.

Clinical staff provided examples of recent care reviews when consumers changed to a new general practitioner with advanced care directives reflecting consumer wishes. Staff explained information on the handover sheet is updated daily to reflect changes that have been made to usual care preferences.

A review of documentation reflected involvement of other organisations and service providers when developing consumer care plans. The service provides a paper-based form for general practitioners to complete to inform the service of outcomes of consultations and prescribed changes.

Staff confirmed they have access to the electronic care plans, although noted that they mostly rely on updated information included in the daily handover sheet provided each shift.

# 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. | Not 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirement 3(3)(a), 3(3)(b) and 3(3)(g) and as a result does not comply with Standard 3.

Requirement 3(3)(a):

While most consumers and representatives confirmed care meets consumer needs and preferences, the Site Audit report noted that consumers had not received effective personal care. Wound management documentation reflected the delivery of wound care, although, for consumers with pressure injuries, the early recognition of injury was missed and classification of injuries were inconsistent with available photographs.

The Site Audit indicated there were deficits in personal care based on observations of consumer grooming not being attended, particularly fingernail care, mouth care and consumers wearing food-stained clothing. Wound management reviewed for the sampled consumers showed deficits in understanding classification of wounds and recognising early signs of pressure injury development.

The response indicated that reporting had been attended where it was evident that care provided to consumers had not been adequate. Education has been provided to the clinical team related to early identification of clinically deteriorating residents, pressure injury classification and prevention and management and oral health for palliative care residents. The response refers to actions to improve individual consumer care and wound management improvements. The response also refers to information included in response to standard 8 however, the PCI does not include specific actions related to Requirement 3(3)(a) to reflect the Site Audit observations, rather includes information related to use of a psychotropic register. I acknowledge the response which provides information related to some areas of the identified concerns, although note that the risks associated with this area are significant if not managed adequately. I consider further time is required to ensure appropriate actions are implemented and sustained in practice. As a result, I find this Requirement non-compliant.

Requirement 3(3)(b):

The service identified pressure injuries and weight loss as the high impact high prevalence risks for the consumers. The Site Audit noted that incidents were not being investigated or analysed for gaps in staff practice and knowledge. Fifty four of 96 reported falls had not been finalised or analysed, 22 of 26 medication incidents had not been finalised and where self-administration of medication was occurring, inadequate assessment or documentation was completed. There was evidence of inadequately managed responsive behaviours and inconsistent documentation surrounding Serious Incident Response Scheme (SIRS) reporting.

While staff are reporting and following relevant procedures according to their role and scope of practice, there is no clinical oversight by management to finalise and analyse incidents, or evidence provided of actions to review processes or provide skills training for staff.

The response acknowledged the deficits identified in the Site Audit and indicates that a review of all identified incidents has now been commenced with actions implemented where required and the addition of an incident tracker dashboard to oversee clinical trends. As these actions are currently in progress and are not specifically identified on the PCI for evaluation, I find this Requirement non-compliant.

Requirement 3(3)(g):

Staff explained their understanding of how to recognise and implement actions to minimise the spread of infection in relation to potential and actual infectious outbreaks. Antimicrobial stewardship is generally understood in the treatment of acute infections with short courses of antibiotics and other non-pharmacological measures to reduce infection. However, the service has 13 consumers listed as requiring prophylactic antibiotics with 10 consumers having as required topical antimicrobial agents prescribed, and 3 consumers who require urinary catheters with prescribed antibiotics, either regular or as required.

The long-term and as required use of antimicrobial agents do not promote best practice and assist in the reduction of antimicrobial resistance in this vulnerable cohort of consumers.

The response and supporting PCI indicated that senior management at the service have now been enrolled and commenced relevant Infection and Prevention Control (IPC) training to support the IPC lead position. The response also indicates that Personal Protective Equipment (PPE) supplies have been made available with staff encouraged to use these appropriately and staff training is planned in infection prevention control in the coming months. The PCI reflects progress toward ensuring adequate monitoring and access to relevant vaccinations is provided as well as effective outbreak management. I note the response also refers to information provided under Standard 7, and Requirement 8(3)(e) indicating that consumers receiving long term antibiotic treatment have been referred to medical practitioners for review, with further review by the Medical Advisory Committee. As a result, I find this Requirement non-compliant.

Compliance with remaining requirements:

Clinical staff demonstrated appropriate recognition of consumers nearing end-of-life and the implementation of care to maximise comfort and maintain dignity. Care documentation reflected staff conduct a palliative care assessment and collaborate with the consumer’s family and the general practitioner to implement holistic palliative care when a consumer reaches end of life.

Consumers and representatives said they were satisfied the service responds to changes in a consumer’s condition in a timely manner. The review of care documentation reflected staff take appropriate action in response to the decline in health condition when an incident occurs and when an escalation in responsive behaviour occurs.

Staff explained the daily updated handover sheet is the main source of information when providing care. Clinical staff confirmed the weekly handover sheet provides changes to consumers across the week, with changes to medications, appointments scheduled, and alerts about the consumer readily available on the paper-based form.

Staff described the service’s referral processes and the process for updating consumer information on the handover sheet, electronic care plan and other relevant information such as the dietary list. Care documentation reflected timely referrals and review by allied health providers when changes in consumer condition or an incident had occurred.

I note the response provides additional information where consumers were identified in the Site Audit report in Requirements 3(3)(d) and 3(3)(e).

# 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. | Not 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

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirement 4(3)(c) and as a result does not comply with Standard 4.

Requirement 4(3)(c):

Consumers provided mixed feedback related to their participation with the limited activities provided within the service, felt they were not supported to do the things that interest them and engagement with the outside community was limited. In the previous 6 months, external lifestyle activities provided by the service were infrequent due to the lack of a service bus or alternative transport. Staff explained the lifestyle staff are often asked to assist ‘on the floor,’ leading to a limited activities program, such as only offering a movie.

The response acknowledges the recommendations listed in the Site Audit report and actions for commencement. A consumer survey has been completed and the service has committed to building a lifestyle program based on feedback from residents and representatives. The PCI indicates additional staff are to be recruited and the service has been selected to pilot the ‘Lifestyle Model of Care Enhancement’ project. I note the proposed improvements and the plan to provide additional staff training, review lifestyle documentation as well as implement a meaningful lifestyle program. I encourage the service to progress and sustain these actions to improve the consumer experience. As these actions are in their infancy, I consider additional time is required to implement and find this Requirement non-compliant.

Compliance with remaining requirements:

Most consumers and their representatives were satisfied consumers receive services and supports which optimise their independence, wellbeing, and quality of life. Care and lifestyle staff said they understood individual consumer preferences and based activities on the consumers’ preferences and needs. The service has an inhouse chaplain who confirmed they provide support and comfort to residents daily, conduct regular church services and small group activities. Care planning documentation was consistent with consumer interviews, detailing individual emotional support strategies and how these are implemented.

Clinical and care staff confirmed the handover process keeps them informed regarding updates to consumer care and services. Care documentation reflected consumer conditions, needs, and preferences are mostly identified and staff can access these through the service’s electronic management system. Consumer care documentation also demonstrated the service collaborates with external providers to support the diverse needs of consumers.

Meal options are varied, interesting, of high quality and a satisfactory quantity. Three consumers said that the meals have improved significantly since the service has been contracted and there is always plenty to eat. Consumers said the kitchen was able to provide an alternative to the menu and were always obliging. Food service staff were well informed about individual consumer preferences and dietary requirements.

Maintenance staff identified how the service has a preventative maintenance schedule and how staff log requests and the requests are checked in the upkeep system each morning and attended on the day. Mobility walking aids, and wheelchair used were observed to be clean and in good working order. Care staff confirmed the service conducts regular inspections on all equipment to ensure operational integrity and safety, and they have access to equipment when required.

I note the response provides additional information where consumers were identified in the Site Audit report in Requirement 4(3)(c).

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

The service was observed to be clean and well-maintained, with wide uncluttered corridors and colourful artwork on the walls. The service includes communal spaces inside and outside which support consumers’ independence and interactions with one another.

Consumers expressed satisfaction with the service environment being safe, homely, and comfortable. The service demonstrated an effective preventative and reactive maintenance process. Cleaning and maintenance logbooks were observed to be up-to-date and completed in a timely manner.

Consumers were observed to have dedicated equipment in their rooms, and where equipment was shared between consumers, staff explained that the equipment is cleaned after each use. Maintenance staff outlined how they review the request log each morning to identify urgent repairs. Consumers and representatives said call bells were in working order and were observed to be in the reach of the consumer when in their room.

# 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 6(3)(c) and 6(3)(d) and as a result does not comply with Standard 6.

Requirement 6(3)(c):

Consumers and representatives reported that the service does not address complaints or make changes in response. This was demonstrated in the complaints register which recorded complaints with no follow up actions and examples of complaints raised by consumers or staff which had not been logged in the feedback system. Care staff were not aware of open disclosure and had not received any training in open disclosure.

The response indicates that due to recent changes in management, not all feedback and complaints have been captured. Additional information supporting resolution of an outstanding complaint was also provided as well as strategies for ongoing feedback and complaints management. I acknowledge the Approved Provider’s approach to supporting the service back to ensuring feedback and complaints are adequately managed and consider additional time is required to reflect improvement. As a result, I find this Requirement non-compliant.

Requirement 6(3)(d):

Consumers and representatives explained they were not aware of any improvements in services following their submission of complaints and feedback. Management acknowledged that the recording of feedback and complaints is inconsistent, and that consumer and representative feedback is often unrecorded, making follow-up and review difficult. In addition, the service’s PCI did not reflect trends in feedback and complaints.

The response indicates that due to recent changes in management, not all feedback and complaints have been captured. Additional training and support have been provided to the service to ensure this is an area of focus and improvement. Regular meetings have been scheduled to ensure ongoing monitoring and trending of feedback and complaints. I acknowledge the Approved Provider’s approach to supporting the service back to ensuring feedback and complaints are adequately managed and consider additional time is required to reflect improvement. As a result, I find this Requirement non-compliant.

Compliance with remaining requirements:

Consumers and representatives sampled said they understand how to give feedback or make a complaint, they feel comfortable doing so. The service has procedures and systems to ensure consumers and their representatives are encouraged and supported to provide feedback or make complaints. Consumers described how they provide feedback on their care and services, saying they speak directly to staff if they have any issues.

The service has advocacy and language service information available on the communal area noticeboard and reception areas for consumers and representatives to access. Staff demonstrated their awareness of how to access external interpreting services if required for a consumer providing feedback or lodging a complaint. The service shares information about the role of the Commission and other external advocacy bodies in the consumer admission pack, in newsletters and displayed throughout the service.

I note the response provides additional information where consumers were identified in the Site Audit report in Requirements 6(3)(a).

# 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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 7(3)(c), 7(3)(d) and 7(3)(e) as a result does not comply with Standard 7.

Requirement 7(3)(c):

The service was unable to demonstrate how they monitor and ensure the workforce has the qualifications and knowledge to perform their roles. Management did not provide records of staff competencies for medication administration or position descriptions outlining the roles and responsibilities of staff when asked by the Assessment Team.

The response provides a number of actions to be implemented broadly across Standard 7 which will support improvements related to staff management. I note that Requirement 7(3)(c) is not specifically reflected in the PCI and encourage the service to ensure further actions are implemented to support appropriate documentation and monitoring of staff competency and qualifications. As a result, I find this Requirement non-compliant.

Requirement 7(3)(d):

The service has an education program, however, there was no evidence of how staff educational needs are effectively monitored and supported. Management acknowledged there are gaps within existing training, and processes are not consistently followed. Management was not able to show how staff mandatory training completion was monitored. Overall staff expressed dissatisfaction with the training provided and several new staff members said they had not completed any mandatory training.

The response indicates that management are developing an onboarding checklist to ensure relevant probationary reviews are conducted, as well as an update to the employee handbook with information on accessing resources. All staff have now been provided with position descriptions and the service has commenced monthly orientation sessions. The service will hold three days of mandatory training as well as access to flexible learning through staff meetings and handovers. A leadership program has been commenced and an employee engagement survey conducted with actions and improvements identified. I acknowledge the proposed actions and consider additional time is required to ensure these actions are implemented. As a result, I find this Requirement non-compliant.

Requirement 7(3)(e):

Management confirmed that performance appraisals had fallen behind and no staff appraisals have occurred since March 2022. Staff reported they had not had a performance review for over a year and new staff had not received a three-monthly probation review in line with the service’s protocol. A PCI action was listed in January 2024 to undertake staff performance reviews; however, no appraisals have been completed at the time of the Assessment Contact.

The response indicates that a new performance management process has been implemented for more efficient tracking of performance reviews, with all staff assigned to complete a performance review. I acknowledge these actions and consider additional time is required to ensure improvements are implemented effectively evaluated. As a result, I find this Requirement non-compliant.

Compliance with remaining requirements:

Consumers and representatives were satisfied that staff had the knowledge and skills to meet care needs and are generally satisfied with the staffing levels at the service. Management described staff planning and recruitment initiatives supported by the organisation to support consumer current care needs. Staff reported staffing levels are good and allow them to complete their assigned task.

Consumers and representatives were also satisfied with how staff interact with consumers in a kind and caring manner. Staff demonstrated they are familiar with consumers’ individual needs and respectful of consumers’ backgrounds and cultures.

I note the response provides additional information where consumers were identified in the Site Audit report in Requirements 7(3)(a).

# 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. | Not 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. | Not 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 8(3)(c), 8(3)(d), 8(3)(e) and as a result does not comply with Standard 8.

Requirement 8(3)(c):

Although management was aware of the organisation-wide policies regarding the collection and actioning of feedback and complaints, as well as the electronic system used to collect these, they acknowledged that they do not always record feedback and complaints in this way, leading to issues with tracking and following up and therefore providing accurate and timely information upwards to the governing body. The service is also not following its procedures for managing staff training and staff performance and clinical staff lacked knowledge regarding legislative obligations relating to reportable and non-reportable incidents.

There is no evidence to demonstrate that the service has a consistent or methodical approach to ongoing monitoring and review of service improvement. The Site Audit report noted that no actions recorded in the PCI had progressed, with some actions dating as far back as 2021.

The response referred to relevant actions in Requirements 6(3)(c) and 6(3)(d) which acknowledge significant area for improvement related to the recording and analysis of feedback and complaints. Additionally, the response reflects that a review has taken place of the PCI with incorporation of actions related to feedback and progression of commenced actions. There is also a plan to table the PCI for review at regular resident and representative meetings to ensure engagement with ongoing improvement actions. I acknowledge the response and the work toward ensuring an effective feedback and complaints process is embedded, I encourage the service to continue to implement improvements and actions as outlined in the PCI. I consider additional time is required to ensure these actions are implemented and evaluated. As a result, I find this Requirement non-compliant.

The Site Audit report noted the service’s information management systems were effective and fit for purpose and can allow staff to access relevant documents and policies related to the care and services provided to consumers. Finance is adequately governed, with management explaining they can approve short-term increases in expenditure, while authorisation is required from the governing body for expenditure increases that are greater or longer-term.

Requirement 8(3)(d):

The service provided policies and procedures to support the management of risk in response to incidents, however, the service did not demonstrate how high impact or high prevalent risks are effectively managed. The service did not demonstrate appropriate clinical oversight to ensure consumers are receiving safe and quality care. The service also did not demonstrate that the risk management systems ensure risks are managed appropriately.

There is no clinical oversight by management to finalise and analyse incidents, or evidence provided of actions to review processes or provide skills training for staff. Identified areas of high impact or high prevalent risks are not adequately monitored or treated according to best practice principles. Staff could not describe the reportable incident system and outline their reporting responsibilities based on their position or an understanding of priority 1 and 2 SIRS incidents.

The response indicates that consumers identified with high impact high prevalence risk have been reviewed as well as the service’s complex care register to ensure adequate monitoring of identified consumers. Compliance audits are to commence and the implementation of a psychotropic register to further monitor use of psychotropic medication. Additional strategies to monitor clinical conditions as well as education and training on relevant reporting. Clinical trends are now being monitored through the incident tracker dashboard and the handover process has been reviewed. I note the actions commenced and consider the risk associated with these areas to be significant where improvements are not successfully implemented. I consider additional time is required to sustain actions in practice. As a result, I consider this Requirement non-compliant.

Requirement 8(3)(e):

Management did not demonstrate how the service monitors the usage of antibiotics, antifungals, and antibacterial medication. Management advised the service does not currently have an IPC lead. The area manager is acting as the IPC lead; however, they do not hold appropriate qualification and were not rostered in a clinical role at the service. Staff were also unaware of how to access the service’s outbreak management plan.

Staff were not familiar with the term open disclosure and while management asserted training related to open disclosure had been provided, no evidence was available to support this.

The response indicated that all consumers receiving long term antibiotics have now been referred to their medical practitioner for review and training has commenced for senior management stepping into IPC lead positions. I acknowledge the actions proposed and further training to support antimicrobial stewardship and open disclosure awareness. Further time to evaluate and monitor improvements in these areas is required. As a result, I find this Requirement non-compliant.

There was evidence of adequate clinical governance related to minimising use of restraint.

Compliance with remaining requirements:

Most sampled consumers and representatives expressed satisfaction with their involvement in how the service is run and broader service improvement through advocacy meetings and individual care plan consultations. Management described how consumer input is obtained in the development, delivery, and evaluation of care and services through surveys and meetings.

The organisation has a range of policies and procedures that support and guide management and staff in providing a safe and inclusive culture. Management described how the organisation communicates with consumers, representatives, and staff regarding updates on policies, procedures or changes to legislation. These are communicated through staff emails, staff meetings, ‘resident-relative’ meetings and newsletters. The board communicates directly to stakeholders and through the committee structures as appropriate.

I note the response provides additional information where consumers were identified in the Site Audit report in Requirements 8(3)(a).

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)