Performance

Report

**1800 951 822**

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| Name: | Blue Care Mackay Homefield Aged Care Facility |
| Commission ID: | 5122 |
| Address: | 87-95 George Street, MACKAY, Queensland, 4740 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 24 October 2023 to 25 October 2023 |
| Performance report date: | 21 November 2023 |
| Service included in this assessment: | Provider: 314 The Uniting Church in Australia Property Trust (Q.)  Service: 3479 Blue Care Mackay Homefield Aged Care Facility |

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 Blue Care Mackay Homefield Aged Care Facility (**the service**) has been prepared by K. Reed, 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 Assessment contact (performance assessment) – site 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 15 November 2023
* the Performance report completed 14 June 2023, following the Site audit completed 09-11 May 2023
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all Requirements were assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not applicable as not all Requirements were assessed** |
| **Standard 7** Human resources | **Not applicable as not all Requirements were assessed** |
| **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.

* Assessment and planning processes must be inclusive of the risks to consumers.
* High impact risks to consumers must be effectively managed.
* Governance systems relating to continuous improvement, workforce governance and regulatory compliance need to be effectively managed.
* Risk management systems need to be inclusive of high impact risks to consumers and an effective incident management system.

# 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 |

Findings

Consumers were treated in a kind and dignified manner with consumers’ lifestyle preferences supported and care needs completed in a timely manner. Staff described practical ways they ensured consumers were treated with dignity and respect and understood consumers’ individual backgrounds, interests and preferences. The service had systems in place to ensure consumers were treated in a dignified and respectful manner with their identity maintained.

Staff supported consumers with their care and service preferences and facilitated lifestyle choices for consumers to support consumers’ identity. Staff ensured consumers’ hygiene and toiletry needs were met in a timely manner, and ensured consumers were dressed and ready for family visits, church, and community outings.

Management described systems undertaken to monitor consumers were treated with dignity and respect and their identity was valued such as walking through the service daily and checking in with consumers regarding any concerns the consumers may have, monthly consumers’ meetings, and reviewing and actioning consumer or representative complaints.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included consumers were not assisted with toileting in a timely manner which impacted their dignity and consumer lifestyle preferences were not supported by staff practices.

Training was provided to staff in relation to staff treating consumers with dignity and respect and upholding consumers’ identity. Training records for June 2023, identified staff attended training on dignity and respect. The service’s plan for continuous improvement identified extra training for staff in relation to dignity and respect was completed by 25 August 2023.

Dignity and respect have been added as an agenda item to all staff and consumer/representative meetings. Minutes of staff meetings for July 2023, identified staff discussed dignity and respect and valuing consumers’ identity.

Management complete daily walks through the service and observe staff interactions to ensure interactions with consumers are respectful.

Formal audits were completed weekly to monitor consumers were treated in a dignified and respectful manner. Review of the audits demonstrated weekly completion and issues were identified and actioned. From May to July 2023 during the weekly audits, consumers were asked if staff were treating them in a respectful and dignified manner and 98% of consumers reported they were treated in a positive way by staff.

For a named consumer who previously had concerns their lifestyle choices were not respected, case conferencing was completed with the consumer and their representative to plan preferences of care and services. The named consumer confirmed their lifestyle choices were now respected by staff.

Based on the information recorded above, this Requirement has returned to Compliance.

# 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. | Not Compliant |

Findings

Processes to identify risks in relation to consumers with a change in their health condition, challenging behaviour risks associated with time sensitive medications and restrictive practices were not effective. Representatives were not satisfied in relation to effective communication and not being informed about risks identified during assessment and planning.

Representatives provided feedback the service did not effectively communicate the known risks from assessment and planning, in relation to chemical restraint and time sensitive medications. Feedback was provided that the risks and side effects associated with the prescription of psychotropic medication were not discussed with a named representative. Other feedback included the risks associated with time sensitive medication were not understood by staff as a named consumer had not received their medication as prescribed.

Assessment and planning documentation did not effectively consider the behavioural risks to assist staff in providing care and services to meet the consumers’ needs. For two named consumers with changed behaviours including verbal and physical abusive behaviours, care planning documentation did not contain strategies to support staff in managing the behaviours.

Processes to ensure consent and authorisations for restrictive practices were ineffective, as seven of eight consumers did not have appropriate documentation and were not informed of the risks associated with restrictive practices. Registered staff were unaware consumers and representatives needed to be provided information from assessment and planning in relation to risks associated with chemical restraint. Staff stated they inform consumers and representatives they needed to sign the consent form as the Medical officer had prescribed the medication. Management confirmed restrictive practices training has not been completed to a level to ensure staff were aware of their responsibilities in notifying families of risks.

Management confirmed there were 21 overdue care plans requiring assessment and planning updates to be completed by the end of December 2023. Management stated there were some staff that required training in completing assessment and planning effectively and training will be completed by November 2023.

The Approved provider in its written response to the Assessment contact -site report has stated the service is not yet where it would like to be in relation to improvements and returning to Compliance. The Approved provider is working to stabilise the service to ensure a consistent approach to the management of the home and monitoring of care and service delivery.

For the two named consumers with changed behaviours and a lack of strategies to manage their behaviours, case conferencing was arranged, and referral to externa; dementia advisory services was arranged. Following the case conference for on of the named consumers, the behaviour support plan now includes strategies to support staff in managing incidents of challenging behaviours, the revised care plan has been printed and placed in the nurses’ station, and staff are required to acknowledge their understanding of the care plan.

In relation to feedback risks relating to restrictive practices and time sensitive medication were not considered in assessment and planning, case conferencing was held with two named consumer representatives, and staff have been alerted and educated regarding the importance of administering time sensitive medication on time.

The Approved provider in its response stated current process for monitoring and review of restrictive practice and risk was not effective. New processes have been introduced including hard copy folders and the responsibility of monitoring the folders has been given to the Quality compliance support officer. The involvement of consumers and their representatives in assessment and planning in relation to risks was discussed at registered staff meetings. In relation to registered staff being unaware consumers and their representatives needed to be provided information in relation to the risks involved with restrictive practices, the Approved provider has stated commencing 20 November 2023, two registered staff members will undergo intensive coaching with an experienced senior clinician, to enable an understanding of restrictive practices.

In relation to overdue care plans requiring assessment and planning updates, clinical management is prioritising review of care plans for consumers who have experienced a change in care needs or has a restrictive practice. The service has reintroduced the ‘resident of the day’ process as an additional method to identify if changes are required prior to the completion of a full care plan review. Staged training will be provided to upskill nursing staff in assessment and care planning.

The Approved provider in its response has stated while education on restrictive practices had been delivered to staff, feedback was provided the education was not sufficient or comprehensive in areas pertaining to risk, education will be provided as part of the two week intensive training with an experienced clinician, and one hour education sessions will be provided over a three day period 29 November 2023 to 01 December 2023.

Based on the evidence contained in the Assessment contact – site report Approved provider’s response and their transparent approach to the service’s difficulties in sustaining improvements and returning to Compliance, this Requirement remains Non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The high impact of risk to consumers requiring time sensitive medication was not managed effectively. Staff were unaware which consumers required time sensitive medication and for one named consumer requiring time sensitive medication, their medication was either administered late or not documented as administered. The risk of chemical restraint had not been shared with consumers’ representatives, prior to consent being sought. The risk of clinical deterioration was not managed for a consumer with weight loss and a subsequent infection.

For one named consumer who required time sensitive medication four times daily to manage their Parkinson’s disease, medication chart entries indicated they did not receive their medication on 12 occasions, and their medication was administered late on 13 occasions between 11 and 25 October 2023. The named consumer’s representative confirmed the time sensitive medication was often not provided on time, and care documentation evidenced the named consumer had difficulty mobilising.

Staff were aware of the requirement for the consumer to receive time sensitive medication and were unable to explain delays in the administration of the medication. Management provided feedback an alert had not been activated to alert staff the consumer had time sensitive medication.

The Approved provider in its written response to the Assessment contact – site report has provided information that the named consumer’s time sensitive medication requirements have been discussed with staff, incidents of missed or late administration have been reported as incidents of neglect to the Serious incident response scheme, and open disclosure processes have been followed with the representative of the named consumer. Administration of time sensitive medications are being monitored on a weekly basis.

For a second named consumer a weight loss of 11.9kgs was recorded between May and October 2023. The consumer was reviewed by a Dietitian and subsequently referred to a Speech Pathologist due to swallowing difficulties. The named consumer had refused to wear their dentures the previous week, however, consideration was not given to correlate the consumer’s refusal to wear their dentures and a possible infection or inflammation to her gums. The named consumer was transferred to hospital 19 October 2023, and was diagnosed with an infection to their salivary gland, requiring antibiotics. Management was not able to explain why the consumer’s weight loss had not been identified or addressed, or that a review of the consumer’s mouth had occurred.

The Approved provider in its written response has acknowledged care documentation did not evidence timely action in relation to the named consumer’s weight loss and change in condition. The Approved provider has sated upskilling of registered staff already noted in Requirement 2a) will contribute to improvement in documentation, follow up and accountability.

For seven consumers requiring restrictive practices, consent or authorisation had not been obtained from the Medical officer or consumer or consumer representative, this included consent for both mechanical and chemical restraint. For two of the consumer representatives’ feedback was provided they were unaware of side effects and risks associated with the restrictive practices.

The Approved provider has undertaken a review of the seven consumers noted above and is liaising with medical officers and nurse practitioners to reduce or cease chemical restraint if reasonable. The five consumers noted in the Assessment contact-site report to be mechanically restrained, the Approved provider has refuted this information.

Behaviour support plans for consumers requiring chemical restraint were not tailored to the individual consumer’s support needs. Incidents of challenging behaviours had not been captured in incident reporting, or assessed to indicate if the incidents were reportable as per legislation. Consumers exhibiting ongoing challenging behaviours had not been referred to behaviour management services for advice in managing their behaviours.

The Approved provider in its written response has committed to challenging behaviour management and the importance of escalating concerns was discussed at the registered staff meeting 31 October 2023, and at the care staff meeting 01 November 2023.

Based on the evidence contained in the Assessment contact – site report and the Approved provider’s response and their transparent approach to the service’s difficulties in sustaining improvements and returning to Compliance, this Requirement remains Non-compliant.

# Standard 6

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| Feedback and complaints | |  |
| 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

**Requirement 6 (3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.**

Consumers and representatives confirmed appropriate action was taken in response to complaints. The service had policies and procedures that guided staff about complaint management and open disclosure. The service’s procedures required the severity of each complaint to be rated and management investigated all complaints applying the philosophy of open disclosure. The details of each complaint and actions taken were recorded. Management and staff understood the open disclosure process. The service monitored the effectiveness in complaints management.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included complaints not being actioned in a timely manner or an open disclosure process was not consistently applied.

Complaints management and open disclosure process and training was provided to staff. Review of training records and staff meeting minutes for May, June and September 2023 demonstrated training was provided on open disclosure and recording of complaints by using the service’s electronic complaints system. Staff confirmed training was provided in relation to complaints management and open disclosure.

Consumers and representatives were advised of the service’s feedback and complaints process and how to make a complaint. Consumers’ meeting minutes and newsletters provided to consumers and representatives via email, demonstrated information provided on the service’s complaints mechanisms. Consumers and representatives provided feedback they knew how to raise any concerns they had with staff or write on the service’s feedback forms. Representatives confirmed they could email the service’s management with any concerns they had.

The service installed feedback locked boxes and feedback forms throughout the service and staff collected feedback forms daily and entered the feedback into the electronic complaints system. Management reviewed the electronic complaints system for completion of complaint review, actions taken, and open disclosure had been provided to the complainant.

Based on the information recorded above, this Requirement is now Compliant.

**Requirement 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services.**

Feedback and complaints were used to improve the quality of care and services. Consumers were satisfied their feedback was used to improve the quality and care and services they received. Complaints are investigated and overseen by management and where appropriate the service’s processes were reviewed and improved.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included the service was not consistently reviewing and utilising feedback and complaints to improve the quality of care and services.

Feedback and complaints were monitored by management to identify opportunities to improve the quality of care and services. Improvements to the service from complaints and feedback was added to staff and consumer/representative meeting as a standing agenda item to monitor the effectiveness of the improvements. Review of the staff meeting minutes outlined that hospitality staff were to inform care staff when morning and afternoon tea were provided to consumers.

Based on the information recorded above, this Requirement is now Compliant.

# 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)(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

**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.**

Consumers were satisfied with the quality of care and services delivered and with the availability of care and support staff. Policies and procedures were available to guide management and staff in planning and rostering. The service’s base roster was planned to ensure sufficient clinical, care and hospitality staff were available to meet the needs of consumers. The base roster was adjusted when the needs of consumers changed. Staff on leave were replaced. Registered nurses were available at all times. The response of staff to call bells was monitored.

Consumers, including consumers who required more than one staff member to provide their care were satisfied with the availability of staff. Representatives were also satisfied with the availability of staff. Care staff were satisfied with the roster, stating over the past few months there had been additional staff and that staff were replaced if someone called in sick.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included insufficient numbers of staff, impacting on care delivery for consumers.

The service appointed a full-time rostering officer on 7 August 2023. This ensured one person managed the staffing daily. The Rostering officer managed the base roster and the daily staff allocation sheets. The Rostering officer completed four daily walk arounds to ensure staffing levels were current and could support the care and service needs of consumers in real time based on feedback from staff and consumers.

The service completed a regular review of both the roster and allocation of staff. This resulted in increased recruitment, with additional staff recruited between June and October 2023 covering areas including registered staff, care staff and a full-time physiotherapist. The use of agency staff was monitored to ensure continuity of care by the staff member ensuring knowledge of each consumer’s care and service preferences. Agency staff familiar with consumers were generally rostered onto areas of the service they were familiar with. A review of the base roster reflected the roster was always based on a full occupancy of consumers at the service. The service produced a report relating to unassigned shifts, demonstrating that during the month of September 2023 97% of all shifts allocated at the service were filled. Both staff and consumers supported the current roster was sufficient to enable the effective delivery of care and services.

A staffing hours report was monitored fortnightly to manage staffing in line with budgeted hours to ensure staffing supported the needs of consumers. The report dated 16 October 2023 evidenced staffing was allocated to support budgeted hours reflective of numbers of staff to support care and service delivery.

To monitor staff practice to ensure delivery of care and services was delivered by sufficient staff, an observation tool was used to monitor through observation if duties were being completed or not. If not, these observations were discussed and addressed, and if required additional staff would be allocated to those areas where deficiencies had been identified.

Increased call bell monitoring and analysis of response times, commenced in July 2023 and was ongoing. Call bell response reports identified an improvement in staff response to call bells. Registered staff meeting minutes 12 October 2023, evidenced discussion on call bell monitoring and reminding of staff to attend to call bells and turn them off when responding. Staff confirmed involvement in discussions on call bell response times and monitoring.

While deficiencies have been identified in Standards 2, 3 and 8, it is my decision these deficiencies are not related to insufficiency of staffing. Therefore, it is my decision this Requirement is now 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.**

The workforce was monitored for qualifications and knowledge, and staff registration records were reviewed by the service. Staff received education and training in antimicrobial stewardship and restrictive practice. Consumers were satisfied staff were competent and could perform their roles. Most consumers and representatives provided feedback staff knew what they were doing and provided quality care and services. Position descriptions set out the key criteria for each role including the qualifications, competency and knowledge required.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included staff competency not being monitored to ensure sound knowledge of antimicrobial stewardship and restrictive practice. Staff registrations were not monitored for currency.

A spreadsheet was developed to monitor staff registrations ensuring staff employed at the service had current registrations. The Residential service manager was responsible for the monitoring of registrations. The registration sheet evidenced all registered staff at the service held a current registration.

Staff have received education regarding incident management and medication. Staff competency in medication delivery was monitored through staff registration as an organisation policy ensuring staff were competent. Medication incidents were monitored, and staff education and training occurred when a medication incident occurred. The service completed competency education in relation to antimicrobial stewardship, and training records evidenced registered staff had completed training and education during the months of July to September 2023. The service provided education for staff on dementia. Staff working in the Memory support unit demonstrated an understanding of dementia management.

While education was completed in relation to restrictive practices, deficiencies remain in relation to authorisation and consent to restrictive practices, it is my decision these deficits are not reflective of a workforce that is not competent. Therefore, it is my decision this Requirement is now Compliant.

**Requirement 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.**

The workforce is recruited, trained, equipped and supported to meet consumers’ needs and preferences. Consumers were satisfied staff have the skills required to deliver care and services that met their preferences and needs. New staff undertook an orientation and completed initial training. Staff were supported in their training and education to enable them to perform their roles.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included processes were not able to ensure all learning needs including mandatory training had been delivered to the workforce to enable them to effectively perform their roles.

A review of staff duties and responsibilities was conducted to ensure staff were aware of their roles and responsibilities. This resulted in new duties lists for staff. Registered staff duties lists evidenced changes, and registered staff confirmed their involvement with the new duties lists.

All staff were provided with mandatory training and education, and all current staff completed mandatory training and all current new staff were undergoing their training. The service demonstrated staff who had not completed their training was due to staff on leave and new staff completing onboarding.

The Hospitality team leader and documentation evidenced support and training have been provided, including education from the regional hospitality partner, buddy shifts and ongoing support from a Hospitality team leader at another organisation service. The Hospitality team leader provided feedback they felt confident in their role and had a sound understanding of how to access assistance if required.

Based on the information above, this Requirement is now Compliant.

**Requirement 7 (3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.**

Consumers were satisfied with the performance of staff. Management monitored and reviewed the performance of staff. Performance was reviewed initially after induction and then at regular intervals. Senior experienced staff supervised new staff until they were competent. Staff confirmed performance monitoring occurred on the job and immediate action was taken if required.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included staff had not received regular assessment and monitoring of their performance.

The service introduced an appraisal and monitoring system based on a Performance development conversation conducted yearly. The process included a formal discussion on performance and education with any identified additional training being supported. The service has developed a tracker to monitor staff performance requirements.

Based on the information recorded above, this Requirement is now Compliant.

# 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. | Compliant |

**Findings**

**Requirement 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.**

Consumers and representatives confirmed they were provided opportunities to engage with the service and consumers’ care development and delivery. Management sought consumers’ input and evaluation of care and services. Consumers interviewed who attend consumer meetings confirmed they were provided opportunities to give feedback and were confident management will action and rectify concerns raised. Management described how consumers were engaged at consumer meetings, through surveys, feedback forms and care planning meetings.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included not engaging consumers in the development, delivery, and evaluation of care and services.

Consumer and representative feedback is now included on the agenda for consumer meetings. A review of consumer meeting minutes in July, August and September 2023 document consumers’ input at the meetings.

Regional management attended the service following the previous site audit to engage with consumers and representatives and seek input into their care and services. Following this feedback, the service provided additional choices at breakfast and changed mealtimes. The service’s Plan for continuous improvement included actions taken in relation to feedback related Consumers confirmed the service provided them with opportunities to engage and they were confident management will act upon their feedback.

Based on the information recorded above, this Requirement is now 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.**

The service was governed by an executive leadership team and Board which was accountable to for the delivery of safe and quality care. The organisation promoted and monitored the delivery of safe and effective care through reporting and regular meetings with the service’s management. Management was accountable to the organisation and Board through weekly and monthly reporting. Reporting included the service’s clinical indicators, complaints and progress towards rectifying previously identified non-compliance with the Quality Standards.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included a lack of oversight with incidents and reporting and organisational monitoring systems for compliance.

Weekly reports which included open incidents and complaints, and overdue care plans were provided to the regional management team. The reports were discussed at weekly meetings where outstanding actions were discussed. Trending and analysis of incidents was discussed at regional quality meetings, staff meetings and with the Regional manager. The Regional operations manager ensured the service had investigated and actioned major incidents and reviewed trending of incidents. Organisational oversight of the service’s incidents was evident from a review of meeting minutes, reports and discussions with regional management.

Based on the information recorded above, this Requirement is now Compliant.

**Requirement 8 (3)(c) Effective organisation wide governance systems relating to the following:**

**(i) information management;**

**(ii) continuous improvement;**

**(iii) financial governance;**

**(iv) workforce governance, including the assignment of clear responsibilities and accountabilities;**

**(v) regulatory compliance;**

**(vi) feedback and complaints.**

The service was unable to demonstrate effective governance systems relating to continuous improvement, workforce governance and regulatory compliance. The service demonstrated systems are in place to ensure accountability and actions are completed relating to feedback and complaints and information management.

Continuous improvement

While the service demonstrated the inclusion of feedback in the Plan for continuous improvement, the service had not identified nor included areas for improvement relating to clinical indicators or incidents despite trending indicating areas where improvement was needed. Some improvements described by management relating to clinical indicators or consumer meetings were not documented in the Plan for continuous. Some consumers were unaware of actions relating to issues raised at consumer meetings.

Management demonstrated awareness of 21 consumer care plans being overdue for review, however, this was not documented in the Plan for continuous improvement and actions to rectify the deficit were not documented.

The service had not implemented effective improvements or evaluation of applied improvements to rectify the previously identified non-compliance with the Quality Standards. The service has ongoing non-compliance in four of the 14 Requirements assessed at the Assessment contact – site visit.

The Approved provider in its written response has indicated the management team will review the monthly indicator reports and clinical incidents to identify areas for improvement that will be entered onto the Quality register. Management will ensure consumer and representative feedback from meetings are reviewed for feedback and suggestions, this feedback and suggestions will remain on the meeting agenda to ensure actions and outcomes are reported back to the meeting attendees and documented in the minutes. A plan has been developed to manage the overdue consumer care plans, including the upskilling program for registered staff and a contracted registered nurse to complete assessment and care plans for new consumers who enter the service.

Workforce governance

It was the role of the Care manager to provide clinical oversight to ensure consumers’ clinical care was appropriate and effective and incidents were reviewed. However, gaps in consumers’ clinical care were identified and high impact risks to consumers were not effectively managed.

The Approved provider has noted the Acting Care manager who commenced at the service 23 October 2023 is an experienced clinician and they are confident the Acting Care manager had the skills and knowledge to provide clinical oversight and management of incidents and risks.

Regulatory compliance

The service was not meeting the legislative obligations relating to restrictive practices. Consumers who were subject to a restrictive practice did not consistently have signed consent forms completed. Representatives of consumers subject to restrictive practices were requested to sign the consent form but were not informed of any risks associated with the restrictive practice.

The Approved provider in its written response has contested the number of consumers subject to mechanical restraints and has reviewed these consumers and identified the consumers are no longer mobile and therefore their free movement was not inhibited by the mechanical restraints. An upskilling coaching program will improve staff knowledge on what constitutes a restrictive practice.

The service did not meet the Serious incident response scheme reporting requirements in relation to missed and late time sensitive medications for a named consumer with Parkinson’s disease which occurred on numerous occasions.

The Approved provider has informed registered staff via memorandum and meetings regarding the importance of time sensitive medication. Retrospective incident reports have been sent to the Serious incident response scheme in relation to the named consumer. Ongoing monitoring is to occur in relation to the administration of time sensitive medication.

An incident recorded in the electronic incident management system on 23 September 2023, identified a consumer did not receive their antibiotics for two days following hospital discharge. The antibiotics were supplied by the hospital and prescribed in the medication chart. The incident report identified this as a non-reportable incident, although the incident met the SIRS reporting criteria of neglect.

The Approved provider has stated an incident was reported on 15 November 2023, in relation to the delay in administration of antibiotics.

The service demonstrated systems were in place to ensure accountability and actions were completed relating to feedback and complaints and information management.

While I acknowledge actions taken by the Approved provider to ensure effective information and feedback systems were in place, effective organisational governance was not demonstrated for the remaining subheadings in this Requirement. Based on the evidence contained in the Assessment contact – site report and the Approved provider’s response and their transparent approach to the service’s difficulties in sustaining improvements and returning to Compliance, this Requirement remains Non-compliant.

**Requirement 8 (3)(d) Effective risk management systems and practices, including but not limited to the following:**

**(i) managing high impact or high prevalence risks associated with the care of consumers;**

**(ii) identifying and responding to abuse and neglect of consumers;**

**(iii) supporting consumers to live the best life they can**

**(iv) managing and preventing incidents, including the use of an incident management system.**

Incidents were not consistently documented, evaluated, and analysed to mitigate risk and prevent future incidents from occurring. Falls data identified trending in the time falls were occurring in September 2023, however no analysis or actions were taken to address this information. Behaviour charts, medication charts and progress notes identified episodes of aggressive behaviours and missed medication, these incidents were not recorded in the electronic incident system. Incidents were not reviewed to identify improvements or actions to mitigate risk or future incidents.

The Approved provider in its written response has evidenced a quality activity has been entered in retrospect to changes to staffing and additional monitoring in response to trends in falls. Clinical monitoring is to be completed by the Acting Care Manager or senior Registered nurse. The Approved provider has identified staff require additional training in incident analysis, review and closure. This will be part of the upskilling program for registered nurses.

While I acknowledge actions taken by the Approved provider to improve staff knowledge of escalating and documenting incidents, effective risk management systems and practices was not demonstrated. Based on the evidence contained in the Assessment contact – site report and the Approved provider’s response and their transparent approach to the service’s difficulties in sustaining improvements and returning to Compliance, this Requirement remains Non-compliant.

**Requirement 8 (3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following:**

**(i) antimicrobial stewardship;**

**(ii) minimising the use of restraint;**

**(iii) open disclosure.**

Processes used by staff supported antimicrobial stewardship which was monitored through incident reporting and clinical oversight. Staff understood the principles of antimicrobial stewardship and described the processes involved. Clinical indicators for July, August, September 2023 demonstrated infection rates were tracked and included if pathology was completed prior to antibiotics prescribed.

Consumers and representatives confirmed staff or management had apologised and provided open disclosure where appropriate relating to complaints or incidents. Staff understood open disclosure and were able to provide examples of when this had occurred.

Actions have been taken to address deficiencies in this Requirement following the Site audit conducted 9 -11 May 2023. Deficiencies included a lack of shared understanding of antimicrobial stewardship and inconsistent use of open disclosure.

Education has occurred in relation to antimicrobial stewardship, which was also discussed at registered staff meetings. Infections were trended through clinical indicator reporting. Open disclosure training was completed by staff and discussed at staff meetings. Monitoring of open disclosure processes occurred through the incident management system, whereby incidents cannot be closed until open disclosure is recorded.

Deficiencies in the minimisation of restraint was not identified as a previous deficit in this Requirement, however, a review of consumers requiring mechanical restraint was undertaken by the service, demonstrating restraint is used in the least restrictive format.

Based on the information recorded above, this Requirement is now Compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)