Performance

Report

**1800 951 822**

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| Name of service: | Blue Care Mareeba Aged Care Facility |
| Service address: | 7 MacRae Street MAREEBA QLD 4880 |
| Commission ID: | 5121 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Site Audit |
| Activity date: | 13 June 2023 to 16 June 2023 |
| Performance report date: | 21 July 2023 |

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 Mareeba Aged Care Facility (**the service**) has been prepared by B Bassett, 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; 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 10 July 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Non-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.

* The organisation must have effective organisation wide governance systems
* The organisation must have effective risk management systems and practices.

# 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

The service had previously been found non-compliant in Requirements 1(3)(a), 1(3)(b), 1(3)(c), and 1(3)(e) following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers were treated with dignity and respect, and their culture and diversity valued. Staff were familiar with consumers’ backgrounds and preferences, and how these impacted on their care. Staff were observed speaking caringly and respectfully to consumers, sitting with consumers and being attentive when assisting consumers with their meals. Care planning documents contained information about consumers’ past and present interests and preferences. Actions taken to address the previous non-compliance in Requirement 1(3)(a) included the implementation of monthly consumer surveys, staff training and daily observations by management to ensure interactions with consumers are respectful.

Consumers received care and services that were culturally safe. Consumers’ cultural needs and preferences were recorded in care planning documents to guide staff and inform care and service delivery. Actions taken by the service to address the previous non-compliance in Requirement 1(3)(b) included staff training in cultural competencies, the creation of additional resources to assist staff in communicating with consumers from non-English speaking backgrounds and regular review and updating of care documentation to ensure consumers’ cultural backgrounds are included.

Consumers were supported to exercise choice and independence regarding how their care and services were delivered, and to maintain connections and relationships. Staff described ways they supported consumers to exercise choice on a day-to-day basis, such as catering to consumers preferences for assistance with activities of daily living and assisting them to spend time with friends and family. Care planning documents identified the consumers’ individual choices regarding how care was delivered, who was involved in their care and how the service supported them in maintaining relationships. Actions taken to address the previous non-compliance in Requirement 1(3)(c) included educating staff in providing support to consumers and reviewing care plans to ensure they reflect consumers current needs.

Consumers were supported to take risks which enabled them to live their best lives. Staff described who they support consumers who choose to take risks and the strategies implemented to ensure their safety. The service undertook risk assessments for consumers who wished to take risks. Care planning documents evidenced the service supported consumers to make informed choices about their care and any accompanying risks.

Consumers and representatives were provided information that was accurate, current and easy to understand, and enabled them to exercise choice. Staff described ways in which information was provided, including for consumers who may have difficulty communicating or living with cognitive impairments, for example, through providing newsletters in multiple languages throughout the service. Actions taken to address the previous non-compliance in Requirement 1(3)(e) included purchasing translation equipment, ensuring all consumers have access to activities calendars and ensuring regular consumer and food meetings. In their response to the Assessment Team report, the service also advised a quality improvement has been created to enhance the communication process between residents from culturally and linguistic diverse backgrounds and hospitality staff using, but not limited to, communication cards, including food related cards for help consumers with food choices.

Consumers’ privacy was respected, and their personal information kept confidential. Staff were guided by the service’s privacy policy and procedure which included protocols to protect consumers’ privacy, such as password protection of computers and knocking on doors prior to entering the consumers’ room.

In coming to my decision in relation to this Standard, I acknowledge the actions taken by the service to improve its performance under the previously non-compliant Requirements. I have also placed weight on the positive feedback provided by consumers and representatives regarding these matters. Therefore, it is my decision that all requirements in Standard 1 are compliant and therefore Standard 1 is Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The service had previously been found non-compliant in all the Requirements of Standard 2 following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers and representatives said assessment and care planning delivered safe and effective care and services for consumers. Staff were able to describe the care planning process and how it informed the delivery of care and services. Documentation reviewed demonstrated consideration of potential risks to consumers’ health and wellbeing including, but not limited to, falls, pain management and diabetes management. Actions taken by the service to address the previous non-compliance identified in Requirement 2(3)(a) included reviewing and updating consumers’ care documentation to ensure it reflected individual care needs, discussing case conferencing and care planning as topics at consumer/representative meetings and additional staff training. In responding to the Assessment Team report, the service also advised a full audit of consumer information pertaining to diabetes management is being completed along with individualised instructions for consumers with diabetes.

Review of consumer care documentation demonstrated awareness and support of the needs and preferences of consumers, confirming the service had discussed and documented their preferences for their end of life. Staff described the needs and preferences of consumers, which aligned to consumer feedback and care planning documentation. Actions taken by the service to address the previous non-compliance in Requirement 2(3)(b) included developing a palliative care kit being made available to staff, review of consumers’ advanced care directives and statements of choice and educating staff regarding end of life planning.

Consumers and representatives confirmed they provided input into the assessment and care planning process. Staff described how they partner with consumers and representatives to assess, plan and review care and services regularly or when the consumer’s circumstances changed. Documentation reviewed reflected the inclusion of multiple health disciplines and services into consumer assessments and planning. Actions taken to address the previous non-compliance in Requirement 2(3)(c) included adding care planning and assessment as a clinical meeting agenda item, providing information regarding access to clinical services in consumer newsletters and consumer monthly surveys.

Consumers and representatives said staff discussed consumer care needs and recorded it clearly in their care plans. Consumers and representatives confirmed they could assess a copy of the care plan. Staff confirmed they had easy access to information regarding the outcomes of assessments and reviews, including consumer care planning documents, via handovers and the electronic care management system. Care documentation contained entries reflecting communication with consumers, representatives and others where care was shared. Actions taken by the service to address the previous non-compliance in Requirements 2(3)(d) included education and coaching of registered staff regarding case conferencing and care planning and sending electronic reminders to registered staff when care plans are due for review.

Care planning documentation demonstrated the service regularly reviewed consumer’s health, wellbeing and needs. Staff described the process for reviewing care and services, while incidents trigger reassessment with any relevant changes relayed to the consumers and representatives. Care documentation evidenced the regular review and updating of consumer care plans including when a change or incident had occurred. Actions taken by the service to address the previous non-compliance in Requirement 2(3)(e) included providing registered staff with incident management education and reporting toolkits, including case conferencing and clinical updates in the consumer meeting agenda and providing additional training to staff concerning behaviours of concern.

In coming to my decision in relation to this Standard, I acknowledge the actions taken by the service to improve its performance under the Standard. I have also placed weight on the positive feedback provided by consumers and representatives regarding these matters. In consideration of the information discussed above, it is my decision that all Requirements in Standard 2 are compliant and therefore Standard 2 is Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service had previously been found non-compliant in all the Requirements of Standard 3 following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers received personal and clinical care that was right for them and met their needs and optimised their health and well-being. Staff were able to describe the processes in place to guide them on restrictive practices, skin integrity and pain management. Restrictive practices were managed in line with legislative requirements. Care documentation demonstrated consumers were receiving individualised care and staff were using strategies and clinical management policies and procedures to guide and deliver effective and safe care. However, the Assessment Team, while on site did identify individual incidents where documentation was not completed and the organisation’s falls management policy was not followed. In responding to the Assessment Team report, the service acknowledged these incidents had occurred and advised of actions taken to further educate and train staff individually and generally to prevent further occurrences.

Management trended and analysed high impact and high prevalence risks to consumers, and strategies were implemented to minimise risks. Staff could describe the main risks to consumers and risk mitigation strategies employed, such as the use of repositioning of consumers at risk of developing pressure injuries. Consumers and representatives were satisfied risks were well-managed. The service had a number of policies and procedures to inform staff as to the management of high impact and high prevalence risks. In responding to the Assessment Team report, the service provided additional information on processes commenced to improve communication among staff regarding consumers receiving nutritional supplements.

Care planning documents confirmed consumers who were nearing end of life, had their dignity preserved and care provided in accordance with their needs and preferences. Staff described practical ways in which consumers’ comfort was maximised and their dignity preserved. Consumers confirmed their end of life preferences, needs and goals had been discussed and recorded.

Staff said they recognised and responded to deterioration or changes in consumers’ conditions and described how this was reported or escalated as relevant. Care planning documents supported deterioration was identified and strategies were applied in response. Consumers and representatives said the service identifies changes in the health and well-being of consumers and responds in a timely way.

Progress notes, care and service plans, and handover reports provided adequate information to support effective and safe sharing of consumers' information to support care, including contributions by allied health practitioners as relevant. Staff described how information and up-to-date conditions, needs, and preferences were documented in the service’s electronic care management system.

The service had a network of approved individuals, organisations and providers they referred consumers to. Care planning documents reflected referrals to other health professionals were timely and staff understood the process to refer matters to other providers and described how changes in the consumers’ condition would prompt referral to the relevant health professional. Consumers and representatives confirmed referrals were made in a timely manner and in consultation with the consumer.

Consumers and representatives were satisfied with the service’s management of infection control practices especially during COVID-19 outbreaks. The organisation supports the service with IPC planning and outbreak management and had established policies and procedures to guide staff. Staff understood infection minimising strategies and outlined the service’s approach to minimising use of antibiotics including non‑pharmacological strategies. Staff were observed to be adhering to best practice guidelines in relation to infection control.

Actions taken by the service to address the previous non-compliance in this Standard included the compilation of a clinical pathways resource folder to assist staff to quickly access resources, daily clinical monitoring and review of progress notes by the service’s Care Manager, the addition of complex care needs as a clinical meeting agenda item, increased education and training for clinical staff including on issues such as wound and falls management, nutrition and hydration, end of life care, managing clinical deterioration and identifying pain in older people. Additionally, the service’s antimicrobial stewardship policy was updated and an information sheet provided to staff, consumers and representatives.

In coming to my decision in relation to this Standard, I acknowledge the numerous actions taken by the service to improve its performance under the Standard. In consideration of the information discussed above, it is my decision that all Requirements in Standard 3 are compliant and therefore Standard 3 is Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The service had previously been found non-compliant in Requirements 4(3)(a), 4(3)(b), 4(3)(d), and 4(3)(e) following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers and representatives said the service supports consumers’ independence and encouraged participation in activities that reflected their interests and lifestyle needs, goals and preferences. Staff could describe the diverse interests of consumers and identified strategies to promote their involvement. Care planning documents reflected consumers’ preferred activities, and the services and supports required to support this. Lifestyle activities were observed taking place at the service including in the service’s memory support unit which had a separate program to meet the cognitive abilities of consumers.

Consumers and representatives said consumers were supported to maintain social, emotional, and spiritual connections which were important to them. Staff provided examples of spiritual and psychological supports provided to consumers experiencing a change in mood, such as spending one on one time with consumers. Care planning documentation contained information about consumers’ emotional and spiritual or psychological well-being and how staff could support them.

Consumers were supported to participate within and outside the service environment, keep in touch with people important to them, and do things of interest. Care planning documents evidenced consumers participated in the community, pursued their interests, and maintained personal and social relationships.

Information about each consumer’s condition, needs and preferences was communicated within the organisation, and with others where responsibility for care was shared. Consumers felt confident information was adequately communicated. Staff confirmed any changes to the condition, needs and preferences of the consumers was communicated through handovers and emails and recorded in the electronic care system.

Care planning documents evidenced timely and appropriate referrals were made to individuals, other organisations and providers of other care and services to support consumers’ lifestyle and emotional needs. Lifestyle staff explained how they used volunteers to assist consumers and spend one to one time with them and demonstrated awareness of how other organisations could be engaged if relevant to visit the service of provide options for outings. Consumers confirmed they were supported by other organisations.

Consumers expressed satisfaction with the quality and quantity of the food. Care planning documents included information on dietary needs or preferences, and hospitality staff described how they were kept informed of these. Kitchen processes were observed to be organised with meals cooked freshly on site. The service was committed to continually reviewing and improving the dining experience of consumers and monitored feedback through formal and informal mechanisms such as consumer meetings and feedback forms.

Equipment for daily living and lifestyle supports were observed to be safe, suitable, clean, and well maintained. Staff said they had access to equipment they needed, and when issues were identified, they were reported to maintenance.

Actions taken by the service to address the previous non-compliance in this Standard included review of the service’s lifestyle program by an external consultant, recruitment of new staff with increased weekend hours for lifestyle staff, increased documenting of consumers’ engagement in lifestyle activities and recording of their spiritual and emotion needs, the engagement of a chaplain, education for staff regarding recognising indicators of depression, changes in handover processes and a review of external care support options.

In coming to my decision in relation to this Standard, I acknowledge the actions taken by the service to improve its performance under the Standard. I have also placed weight on the positive feedback provided by consumers and representatives regarding these matters. In consideration of the information discussed above, it is my decision that all Requirements in Standard 4 are compliant and therefore Standard 4 is Compliant.

# 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

The service had previously been found non-compliant in Requirements 5(3)(b) and 5(3)(c) following a site audit conducted 3 June 2022 to 6 June 2022.

The service was welcoming, with a layout that is easy for consumers to understand and navigate. Most consumers had access to the outside gardens from their rooms and most consumers had personalised rooms decorated with furnishings and personal items. Consumers confirmed the service environment was easy to navigate, welcoming and homely. Consumers were observed having morning tea, meals and socialising together.

Consumers and representatives said the service environment was safe, clean, well maintained, and enabled consumers’ free movement within and outside of the service. All areas of the service were observed to be safe, well-serviced, and maintained at a comfortable temperature. Maintenance and cleaning staff described their schedules and processes to ensure the service remains clean and operational. During the site audit, the Assessment Team brought some potential environmental hazards to the attention of management and these were addressed immediately. In responding to the Assessment Team report, the service advised that staff were reminded of their obligations to identify and address any potential environmental risks to consumers.

Consumers felt safe when staff used equipment with them and said they had seen significant improvements in maintenance at the service. The service had a preventative and reactive maintenance program. Furniture, fittings, and equipment were observed to be safe, clean, and suitable for the use and needs of the consumer.

Actions taken by the service to address previous non-compliance identified in this Standard included increased staffing hours for cleaning including engagement of external contractors for cleaning of high areas, review of cleaning schedules and duty lists, improved monitoring of cleaning processes and regular talks and meeting with staff regarding cleaning and maintenance expectations and responsibilities.

In coming to my decision in relation to this Standard, I acknowledge the actions taken by the service to improve its performance under the Standard. I have also placed weight on the positive feedback provided by consumers and representatives regarding these matters. In consideration of the information discussed above, it is my decision that all Requirements in Standard 5 are compliant and therefore Standard 5 is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service had previously been found non-compliant in all the Requirements of Standard 6 following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers and representatives said they feel encouraged, safe and supported to provide feedback and make complaints and could describe various methods available for them to do so. Management advised in addition to the feedback and complaints system, consumers were encouraged to provide feedback via consumer meetings, food focus groups, surveys and during the care review process.

Consumers and representatives were aware of and had access to advocates and other methods for raising and resolving complaints. External resources including advocacy and language service were available, and information on accessing advocacy or interpreter services were available around the service. Observations confirmed brochures for advocacy services, external complaints and language support services were available.

The service had processes to follow when feedback or a complaint was received including the use of open disclosure and an apology when things went wrong. Documentation and consumer feedback confirmed, the service acted in a timely manner responding to complaints and an open disclosure process was applied. Consumers and representatives confirmed the service responded in a timely and appropriate manner when feedback was provided.

The service had systems in place to record and trend complaints, feedback, compliments, and suggestions. All feedback and complaints were reviewed and used to improve the quality of care and services. Consumers provided feedback that surveys, meeting and feedback was used to improve the care and services they received.

Actions taken by the service to address previous non-compliance identified in this Standard included discussing the service’s feedback and complaint processes during consumer meetings, providing written correspondence regarding advocacy and language services available to assist consumers, implementing monthly consumer surveys, increased staff training (including on open disclosure) and trending of feedback and complaints to identify areas of improvement.

In coming to my decision in relation to this Standard, I acknowledge the actions taken by the service to improve its performance under the Standard. I have also placed weight on the positive feedback provided by consumers and representatives regarding these matters. In consideration of the information discussed above, it is my decision that all Requirements in Standard 6 are compliant and therefore Standard 6 is 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)(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 had previously been found non-compliant in all the Requirements of Standard 7 following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers and representatives said the care and services consumers received was in line with their needs and preferences. They said staff were kind, caring and respectful and their requests for assistance were generally responded to in a timely manner. Consumers and representatives felt staff were appropriately qualified and knew how to perform their roles. They provided positive feedback in relation to staff capabilities and how their care and services were delivered.

Staff generally said they had enough time to complete their duties and management described strategies employed to replace staff on planned and unplanned leave. Registered and care staff were guided by their position descriptions, workflow documents and duty statements. They confirmed they had received training relevant to their roles.

The organisation has policies and processes to ensure staff are recruited, trained, supported and have the qualifications and knowledge to meet the needs and preferences of consumers across all areas of service delivery. Registered staff qualifications were monitored by the organisation to ensure they remain current.

The service has a suite of documented policies and procedures to guide staff practice and which outlines that care and services are to be delivered in a person-centred manner. Management reviews staff performance on a regular basis.

Training records indicated staff had been provided with additional education opportunities and mandatory education online and face to face. The organisation had policies and procedures in relation to rosters, recruitment, personnel management and dignity and respect.

Actions taken by the service to address previous non-compliance identified in this Standard included review of the service’s base roster to ensure an appropriate mix of staff, ongoing recruitment initiatives, mandatory training regarding treating consumers with respect and dignity, regular review of training records and developing a performance management schedule for all staff.

In coming to my decision in relation to this Standard, I acknowledge the actions taken by the service to improve its performance under the Standard. I have also placed weight on the positive feedback provided by consumers and representatives regarding these matters. In consideration of the information discussed above, it is my decision that all Requirements in Standard 7 are compliant and therefore Standard 7 is 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. | Non-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. | Non-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 had previously been found non-compliant in all the Requirements of Standard 8 following a site audit conducted 3 June 2022 to 6 June 2022.

Consumers and representatives said they felt the service was well run and that they could partner in the delivery and evaluation of care and services, for example, through attending consumer meetings, participating in surveys and using feedback forms. Management described mechanisms to support consumers and representatives to engage in the development, delivery and evaluation of services and provided evidence of where consumer feedback has been used to improve services, for example, via changes to the service’s menu.

The service was able to demonstrate it promotes a culture of safe, inclusive and quality care overseen by its governing body. The governing body regularly reviews information and reports relating to clinical and incident data trend analysis to identify compliance with the Quality Standards and provide monitoring and accountability for care and service delivery.

The service has strategic quality and clinical governance frameworks that promote a culture of safe, inclusive and quality care. The clinical governance framework, in conjunction with clinical policies and procedures, outline the safety and quality systems required to maintain and improve the reliability, safety and quality of clinical care and to improve clinical outcomes for consumers. It includes policies regarding antimicrobial stewardship, minimisation of restrictive practices and open disclosure.

With respect to Requirement 8(3)(c), information in the site audit report indicated that the service has effective organisation wide governance systems with respect to continuous improvement, financial governance, workforce governance, feedback and complaints. However, the Site Audit report indicated deficiencies in effective information management systems with respect to communication of changes to consumers’ care needs and complaints regarding care not being recorded in the services incident management system (IMS). The site audit report indicated deficits in staff understanding and application of the organisation’s information management. It was also noted that audits had not included a review of information management.

Additionally, governance systems were identified by the Assessment Team as deficient with respect to regulatory compliance relating to the identification and reporting of incidents under the Serious Incident Response Scheme (SIRS). The site audit report identified staff did not have a clear understanding regarding principles of neglect where incidents with the potential to cause harm must be reported under SIRS in addition to matters where actual harm has occurred.

In responding to the site audit report the approved provider acknowledged the issues that had arisen and discussed processes commenced to improve how information is managed and shared at the service. This included review of daily progress notes, updating of staff returning from leave and implementation of weekly clinical risk meetings. With regards to regulatory compliance, the approved provider response acknowledged inconsistent monitoring and identification of incidents reportable to the SIRS and outlined actions being undertaken to address this, including daily review of incidents in the IMS, staff education on SIRS reporting requirements as well as one to one education provided to all clinical staff and scheduling of a two day clinical leadership forum to cover topics such as effective clinical monitoring.

While acknowledging the actions taken by the approved provider in this respect, it is noted these improvements will take time to be embedded in usual practice and will need to be evaluated by the service. I have therefore decided that Requirement 8(3)(c)(i) and (v) are Non-Compliant.

In relation to requirement 8(3)(d), information in the Site Audit report indicated there had been underreporting of incidents under SIRS, with unreported incidents concerning incorrect medication received and wound management identified as being reportable. In responding, the approved provider acknowledged the site audit report findings and has implemented additional staff education, additional clinical support staff engagement and onsite management oversight to improve the operation of the incident management system. In coming to my decision with this Requirement, I have considered the information in the site audit report under this and other standards alongside the approved provider’s response. While acknowledging the actions taken by the approved provider since the Site Audit, I note that some of the actions are ongoing and will need to be evaluated. I have therefore decided that Requirement 8(3)(d) is Non-Compliant.

As Requirements 8(3)(c) and 8(3)(d) are Non-Compliant, Standard 8 is Non-Compliant.

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)