Performance

Report

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| Name of service: | Blue Care Rothwell Nazarene Aged Care Facility |
| Service address: | 25-39 Higgs Street ROTHWELL QLD 4022 |
| Commission ID: | 5922 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Site Audit |
| Activity date: | 19 April 2023 to 21 April 2023 |
| Performance report date: | 5 June 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 Rothwell Nazarene Aged Care Facility (**the service**) has been prepared by P. Sherin, 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 26 May 2023 providing additional information.
* 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 | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-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.

* Requirement 2(3)(e) – Ensure 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.
* Requirement 3(3)(a) – Ensure safe and effective clinical care delivery in relation to restrictive practices and wound care and management.
* Requirement 8(3)(c) – Ensure effective organisation wide governance systems in relation to regulatory compliance with serious incident reporting and restrictive practice requirements.
* Requirement 8(3)(d) – Implement effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers, and incident prevention and management.
* Requirement 8(3)(e) – Implement an effective clinical governance framework in relation to monitoring and managing restrictive 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

Consumers and representatives said staff treat the consumer with dignity and respect. Staff were observed treating consumers with dignity and respect and understood the consumers’ background and individual preferences. Care documentation reflected what is important to consumers to maintain their identity. The organisation has documents and processes which outline consumers’ right to respect and dignity.

Consumers said they are satisfied the service meets their cultural needs and provided examples of this. Staff described how they support consumers to maintain their culture and what is important to them. Care documentation includes information related to consumers’ country of birth, relationships, religion, ethnic and cultural practices, and spiritual needs.

Consumers said they are supported to exercise choice and maintain their independence by making decisions about their care and services. Consumers are supported to nominate who they would like involved in their care, communicate their decisions, make connections with others, and maintain relationships of choice. Staff described ways they assist consumers to maintain contact with family and others. The service has a choice and decision-making framework to guide staff practice.

Consumers described how the service supports them to take risks of their choosing. Staff described how risk assessments are undertaken, risks are discussed with consumers and strategies implemented to ensure consumer safety. Policies and procedures are available to guide staff practice regarding consumer dignity of risk.

Consumers and representatives advised they receive up to date information including about activities, meals, COVID-19 and events happening in the service via newsletters, meetings, written and verbal information. Consumer and representative meetings are conducted where information is provided regarding a range of topics. A digital application is available for information sharing between consumers and their loved ones. Posters and flyers of upcoming activities were observed on noticeboards and in consumer rooms.

Consumers and representatives confirmed consumers’ privacy is respected. Staff described how consumers’ personal information is kept confidential such as by not discussing their information in front of other consumers, keeping consumer files locked and computers password protected. Staff were observed locking computers when not in use, respecting consumers’ privacy when delivering care, and providing personal space when consumers’ family or friends visited the service.

I find this Standard compliant as I find all Requirements are 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. | Non-compliant |

Findings

Having considered the Site audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not ensuring care and services are reviewed regularly for effectiveness.

I have made this decision based on the following analysis.

*Requirement 2(3)(e)*

**Site audit report**. The assessment team provided information in the Site audit report evidencing deficiencies in relation to the service not consistently conducting a regular review and update of care plans in response to a change in circumstances or when incidents occur.

* One consumer’s care plan identified they were on a palliative pathway; however, a palliative pathway could not be located, management confirmed they are no longer deteriorating, and the care plan had not been updated to reflect this information.
* A second consumer who had suffered a neck of femur fracture in January 2023 did not have their pain and comfort care plan updated to reflect this information following the fracture.
* A third consumer’s care plan identified they had a wound on their lower left leg whilst the consumer stated their wound was on the right leg.
* For a fourth consumer whilst regular weekly weight checks were occurring in response to weight loss, the nutritional care plan has not been updated to reflect this information.

Upon feedback, management acknowledged regular review and update of some consumers’ care plans had not occurred.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* The provider submitted evidence to demonstrate the first consumer did not meet the criteria for commencement on a palliative care pathway.
* For the consumer who suffered a fracture, the provider acknowledged whilst the pain assessment and care plan had not been updated, the consumer’s physiotherapy assessment and care plan had been updated and strategies to manage pain were being implemented in accordance with the consumer’s needs.
* The provider evidenced the consumer identified with a wound on his lower right leg had wounds on both legs and the information was correct.
* The provider submitted evidence to confirm the fourth consumer’s care plan has since been updated to reflect weekly weight monitoring.
* The provider advised several improvement actions are planned in response to the deficits including the allocation of a senior registered nurse in each residential lodge to monitor and review the completion of assessments and care plans, with 100% review and update of care plans by 31 July 2023. Education on assessment and care planning is planned for all registered staff on 31 May 2023. This topic is to be included as a standard agenda item in monthly registered staff meetings. Spot audits are to be conducted on assessments and care plans to ensure sustained improvement.

**Assessment**. Having considered the Site audit report and the Provider's response, I find deficiencies in regular review and update of care plans remain. I have based this decision on the following:

* Improvement actions have not been fully completed, will require time to be embedded within the service’s processes, and need testing to ensure their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 4 Requirements of Quality Standard 2 are compliant as:

The service demonstrated assessment and planning includes consideration of risks to consumers’ health and wellbeing. Registered staff described the assessment and care planning process, and review of documentation identified most consumers’ assessment and care planning reflect consideration of risks to their health and wellbeing.

Consumers and representatives confirmed assessment and planning identifies their needs, goals, and preferences. Care documentation captures information regarding individual consumers’ needs and preferences, including advance care planning information and end of life wishes where consumers and representatives have chosen to do this. Staff advised there is discussion about a consumer’s end of life wishes when a consumer enters the service, annually, and if a consumer’s condition deteriorates.

Consumers and representatives confirmed the service involves them in assessment and planning and staff speak to them regularly about care and services. Review of documentation identified input from other health professionals and providers.

Consumers and representatives confirmed they are provided a copy of the care plan. Staff described how updates to consumers’ care and services are regularly discussed during shift handovers and a copy of the consumer’s care plan is located in their rooms; this was also observed by the assessment team.

# 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. | Non-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

Having considered the Site audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not ensuring safe and effective clinical care delivery in restrictive practices and wound care.

I have made this decision based on the following analysis.

*Requirement 3(3)(a)*

**Site audit report**. The assessment team's audit report identified deficiencies in the management of the following for some consumers:

* **Escalating behaviours.** For 2 named consumers with behaviours identified by the service to be escalating, referrals had either not been followed through or strategies to manage behaviours have not been effective. Management acknowledged for one consumer they ‘had slipped through the system’.
* **Restrictive practices.** Management and staff could not demonstrate a shared understanding of chemical restrictive practices at the service.

A review of the service's psychotropic and restrictive practice register identified several consumers subject to chemical and environmental restraint without appropriate assessment, authorisation, consent, monitoring and review.

* **Falls.** The service has been unable to implement strategies to prevent repeated falls for 2 consumers despite being referred to an allied health professional following each fall.
* **Wounds**. A review of care documentation identified a consumer with an incident of myiasis. In this case, inadequate wound care was provided, with no measurements or photographs recorded and incorrect dressings applied.
* **Weight loss**. Regular weight monitoring had not occurred to ensure nutritional strategies were implemented and effective for a consumer who had experienced unexpected weight loss.

The audit report identified effective practices in managing skin integrity and pain. Consumers and representatives stated that they were satisfied with personal and clinical care delivery.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* **Escalating behaviours.** Management submitted evidence of referrals being completed for both consumers with behaviours and copies of updated behaviour care plans identifying individualised strategies for the management of their behaviours.
* **Restrictive practices.** The provider said the service was transitioning from a paper-based psychotropic register to an electronic register at the time of the Site audit. The transition led to incomplete or incorrect information being provided to the Assessment team. The provider advised the psychotropic register has since been reviewed and updated.

The provider advised that staff have now been provided training on the new electronic register and that appropriate authorisation/consent forms are in place for consumers subject to a restrictive practice. No evidence was provided to demonstrate the completion of these actions.

The provider advised several improvement actions will be implemented. Improvements include further training, the introduction of monthly restrictive practice audits, and discussions on restrictive practice and the psychotropic register via clinical and registered staff meetings.

* **Falls.** Evidence demonstrated that a comprehensive analysis had been completed for both identified consumers before the Site audit to identify contributing factors and implement fall prevention and management strategies. The provider advised a geriatrician has additionally reviewed both consumers in May 2023.
* **Wounds**. For the consumer who experienced myiasis, the service has highlighted inaccuracies within their incident analysis report, which had not been reviewed at the time of the Site audit. The provider has attributed the cause of the incident to the inexperience of staff and a lack of training for newly registered staff in wound management and the electronic system.

The service has planned improvement actions, including wound care training to staff on 31 May 2023, advanced wound care and management training for the senior clinical team in September 2023, introducing 2 additional days of buddy shifts for newly registered staff, and weekly spot checks of wound charts.

* **Weight loss**. The provider acknowledged the gap in weight charting between 10 January to 11 March 2023 for the identified consumer. They advised that weekly weighs have since occurred, with a dietician review in March 2023 and a geriatrician review in May 2023. Weight is now being managed appropriately for the consumer.

**Assessment**. Having considered the Site audit report and the provider's response, I find deficiencies in restrictive practices and wound care remain. I have based this decision on the following:

* The provider has appropriately responded to issues identified by the Assessment Team with behaviour management, fall prevention and weight loss. In each instance, satisfactory evidence has been provided that the underlying causes of the incidents have now been rectified.
* The provider has taken action to address deficiencies identified in restrictive practices and wound management; however, those improvement actions have not been fully implemented or tested for effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

*Requirement 3(3)(b)*

The assessment team brought forward information in the Site audit report as outlined under Requirement 3(3)(a) above to evidence high impact and high prevalence risks in relation to falls, weight loss and escalating behaviours not being managed effectively for some consumers.

I note the Site audit report evidenced consumer and representative satisfaction with the delivery of personal and clinical care and no concerns were expressed with the management of high impact and high prevalence risks.

The provider in its response submitted additional information as outlined under Requirement 3(3)(a) to demonstrate effective management of risks for consumers in the Site audit report. The provider advised of additional improvement actions to be implemented in relation to each of the above areas. This includes, but is not limited to comprehensive analysis of consumers with behaviours of concern, falls and weight loss by a Nurse Practitioner; introduction of second weekly clinical meetings as a forum to discuss, review and formulate actions to assist consumers with high impact and high prevalence risks; utilisation of a social worker to provide counselling services once a week until consumers are reviewed by external psychologists and geriatricians; training to staff; and introduction of new clinical monitoring processes.

I have considered the evidence presented by the assessment team and the provider; I am persuaded by the positive feedback from consumers and representatives and am satisfied the provider has appropriately responded to identified issues and submitted satisfactory evidence to demonstrate effective management of high impact and high prevalence risks.

I, therefore, find this Requirement is compliant.

*Requirement 3(3)(f)*

The assessment team provided information in the Site audit report to evidence timely and appropriate referrals have not occurred for some consumers. This included 5 consumers with weight loss, frequent falls and challenging behaviours as outlined under Requirement 3(3)(a) above.

I note the Site audit report outlined consumers and representatives ‘were more than satisfied’ with care and services and felt referrals occur in a timely manner where required.

The provider in its response submitted supporting evidence to demonstrate appropriate referrals had either already been made prior to the Site audit or had been completed following the Site audit for all consumers identified in the audit report. This included referrals to dieticians, physiotherapists, geriatricians, dementia support services and social workers.

I have considered the evidence submitted by the assessment team and the provider; I am persuaded by the evidence of actions taken by the provider to complete referrals, and positive feedback received from consumers and representatives.

I, therefore, find this Requirement is compliant.

I find the remaining 4 Requirements of Quality Standard 3 are compliant as:

The service was able to demonstrate care delivery for consumers receiving end-of-life care ensures their needs are addressed, pain is managed, and the consumer’s dignity is maintained. Staff described ways in which they maintain the comfort of a consumer at end of life, provide pastoral care, and support the consumer’s family. The service has policies and procedures to guide end-of-life care delivery and staff said they have received training in provision of end-of-life care.

Care documentation identified staff recognise, report, and respond to changes in a consumer’s condition. Care staff said they notify registered staff if they have concerns about a consumer and registered staff advised consumers are referred to the medical officer, representatives are notified, and transfer to hospital is initiated where required.

Consumers and representatives sampled said consumers’ care needs and preferences are effectively communicated between staff and others responsible for care. Staff confirmed they receive up to date information about consumers’ care during handover and via the electronic care management system.

The service has an outbreak management plan, policies, procedures, and training to guide staff in infection prevention and control and antibiotic management. Screening procedures were observed in place for staff, visitors, and contractors on entry. Infections are reported, analysed, and reviewed through monthly reports and the usage of antibiotics is monitored.

# 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

Consumers expressed the service supports their independence and encourages them to participate in activities which reflect their interests and lifestyle needs. Staff could describe the diverse interests of consumers, including strategies to promote involvement in their care and services. Care documentation identified the interests and activities important to consumers, and provided information to support individual choice, daily living, wellbeing, and service delivery. The service’s monthly activity schedule includes group activities as well as an exercise-based wellbeing program. A dedicated lifestyle staff member supports consumers in the memory support unit with a blend of group activities and one to one support.

Consumers confirmed the service supports their emotional, spiritual, and psychological wellbeing. Staff provided examples of how the service supports consumers including through one-on-one conversation, involvement in activities, mental stimulation via virtual reality headsets, opportunities to attend religious services, and providing privacy during prayer. Care documentation provided information to guide staff in supporting consumers’ individual emotional, spiritual, and psychological needs. The service provides access to a Chaplain, religious and pastoral care volunteers, and a music-based church service for consumers in the memory support unit.

Consumers said they are supported to engage in activities and pursue personal interests inside and outside the service, and to maintain relationships with the people who are close to them. Staff could describe the individual preferences and interests of consumers and provided examples of how the service supports consumers to engage in activities of interest to them, such as by coordinating bus trips and providing televised activities and services for consumers not able to attend in person.

Consumers said their services and supports are consistent, staff know their individual preferences and are confident information is recorded and shared with others when necessary. Staff explained how they are updated on the changing condition, needs or preferences of consumers as they relate to services and supports for daily living, such as via verbal and written handover and updates in the electronic care management system.

The service demonstrated timely and appropriate referrals to other individuals, organisations, or providers and how staff collaborate to meet the diverse needs of consumers. Care planning documentation reflects referrals to various providers and external services.

Consumers expressed satisfaction with the meals provided at the service, and said meals were varied and of suitable quantity and quality. Consumers said they are provided with choices, and alternatives are available if they do not prefer what is offered. Staff explained internal communication and electronic processes used to monitor and support the varying dietary needs and preferences of consumers. The service’s menu is developed based on feedback from consumers and consultation with a dietician.

Equipment being used in common and dining areas, lifestyle areas, and personal rooms was observed to be clean and well-maintained. Staff described processes in place for cleaning, servicing and replacement of equipment.

I find this Standard compliant as I find all Requirements are 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

Consumers expressed how they feel at home at the service and enjoy the outlook of the garden areas. The service’s residential areas provide access to a main dining area, several communal indoor spaces and easy access to the outdoors. There are wide corridors throughout, a café where consumers can meet with friends and family, a hairdressing space, several outdoor garden areas, and a large activity hall. Consumers have personalised rooms decorated with furnishings and personal items which reflect individual tastes and styles.

The design of the service facilitates easy access to all internal and outdoor living areas including dining, entertainment areas and large gardens. There is clear signage to assist with navigating around the service. Consumers have direct access to the outdoors via a private patio. Outdoor areas are appropriately furnished for consumer use. A cleaning schedule is maintained and there are processes in place to monitor this. Maintenance records and observations on site indicated that regular preventative and corrective maintenance is carried out as scheduled. The service was observed to be clean and well maintained.

Furniture, fittings and equipment were observed to be clean, well maintained and suitable for consumer needs. Staff described processes in place to report and escalate maintenance issues, and consumers confirmed maintenance tasks are attended to promptly.

I find this Standard compliant as I find all Requirements are 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

Consumers and representatives said they feel encouraged, safe, and supported to provide feedback and make complaints, and could describe various methods available to do so including speaking to management or staff directly, during consumer meetings, and using feedback forms. The assessment team observed feedback forms and boxes located in the common areas of the service, and information on how to submit feedback and complaints provided under the service’s monthly newsletter.

Consumers and representatives said they are aware of advocacy and language services available to them and referenced the promotional material displayed at the service. Management was aware of how to access these services should this be required. Information on external complaints agencies, advocacy and interpreter services is displayed on noticeboards around the service.

Consumers and representatives confirmed management address complaints and attempt to resolve any concerns promptly. Management and staff demonstrated a shared understanding of processes to follow in response to a complaint and confirmed they have received training on open disclosure. Policies and procedures are available to guide staff regarding feedback and complaints management, and open disclosure processes.

Consumers and representatives expressed confidence in the service using feedback and complaints to improve the quality of care and services. Management advised the service analyses and trends all feedback and complaints and uses this information to inform continuous improvement activities across the service which are documented under the service’s plan for continuous improvement. Review of the service’s feedback and complaints register and plan for continuous improvement confirms this.

I find this Standard compliant as I find all Requirements are 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

Consumers and representatives considered there are enough staff at the service to meet consumer needs. Staff said they can complete the requirements of their roles and provide care and services in a timely manner. Management described the processes in place to cover unplanned absences and periods where staff may need to be furloughed, including by extending shifts, creating half shifts, or accessing staff from the organisation’s nearby services. Call bell audits are conducted every 2 months and response times over 10 minutes in the period audited are investigated to implement improvements.

Consumers and representatives confirmed consumers are treated kindly and with respect. Management said they use consumer and representative feedback through complaints and surveys to monitor staff behaviour and to ensure interactions between staff and consumers meet the organisation’s expectations. Staff were observed assisting consumers with their meals with patience and speaking to consumers in a kind and caring manner.

Consumers and representatives felt the workforce is competent and staff have the knowledge to deliver care and services that meet consumer needs. Staff reported receiving support and assistance to ensure they have the skills and knowledge to undertake their roles. Management advised staff competency is monitored through consumer, representative, and line manager feedback, performance assessments, surveys and reviews of clinical records and care delivery. Processes are in place to record and monitor staff qualifications and criminal record checks.

Consumers and representatives expressed confidence that staff are well trained and know what they are doing. Staff considered they are appropriately trained, supported, and equipped to perform their roles. New staff receive orientation, access to buddy shifts, and are required to complete mandatory training. Management monitors staff compliance with mandatory training through an electronic learning management system and provide staff with additional training where required. Review of mandatory training records identify staff receive training on a range of topics.

The service demonstrated systems are in place to regularly assess, monitor and review staff performance. Staff confirmed they have undergone regular performance appraisals that involved feedback from supervisors on their performance and an opportunity to identify areas for further improvement and training. Review of completed appraisal records identify staff and manager input and areas for development, as well as the management of poor performance.

I find this Standard compliant as I find all Requirements are 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. | Non-compliant |

Findings

Having considered the Site audit report and the provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating effective organisation-wide governance systems in relation to regulatory compliance with serious incident reporting and restrictive practice requirements.
* The service is not implementing effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers, and incident prevention and management.
* The service is not implementing an effective clinical governance framework in relation to monitoring and managing restrictive practices.

I have made this decision based on the following analysis.

*Requirement 8(3)(c)*

**Site audit report**. The assessment team's audit report identified deficiencies in the organisation’s governance systems in relation to the following:

* **Information management**: the Site audit report stated gaps in communication and deficiencies in the review and recording of information have resulted in adverse clinical outcomes for consumers and limited the service’s ability to appropriately manage high impact and high prevalence risks. I have considered this information under Requirements 2(3)(a), (3)(3)(a) and 3(3)(b) above.
* **Serious incident regulatory compliance:** staff were not able to demonstrate a shared understanding regarding the serious incident response scheme escalation and reporting requirements. Review of the service’s incident documentation identified the service had multiple incidents that had not been reported within regulatory timeframes.
* **Restrictive practice regulatory compliance:** a number of consumers were identified as subject to chemical and environmental restraint without appropriate assessment, consent, monitoring and review in place in accordance with regulatory requirements.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* **Regulatory compliance with serious incident reporting requirements**: the provider acknowledged notification had not been made for one incident and refuted findings regarding other incidents not being reported within regulatory timeframes confirming all incidents were reported following the Site audit. Nil information was provided to evidence this. The provider advised improvement actions planned or implemented include providing the senior clinical team access to the reporting portal, re-education to all staff on serious incident reporting, and daily review of incidents by service management to ensure timely notification and reporting. Refer to Requirement (8(3)(d) for additional information.
* **Restrictive practice regulatory compliance:** the provider stated the service was in the process of transitioning from a paper-based psychotropic register to an electronic register at the time of the Site audit; therefore, information provided was incorrect or incomplete. The psychotropic register has since been reviewed and updated, staff have been provided training on the new electronic register, and appropriate authorisation/consent forms are in place for consumers subject to a restrictive practice. Evidence was not provided to demonstrate completion of these actions. The provider advised several improvement actions are to be implemented including training to staff, introduction of monthly restrictive practice audits, and discussions on restrictive practice and the psychotropic register via clinical and registered staff meetings.

**Assessment**. Having considered the Site audit report and the Provider's response, I find deficiencies in governance systems for regulatory compliance remain. I have based this decision on the following:

* The provider has not submitted sufficient evidence to demonstrate effective governance systems in place in response to deficits in regulatory compliance with serious incident reporting and restrictive practice requirements.
* Improvement actions have not been fully implemented or tested for effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

*Requirement 8(3)(d)*

**Site audit report**. The assessment team evidenced ineffective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers and managing and preventing incidents.

* The Site audit report stated gaps in staff practice have impacted the service’s ability to effectively manage high impact and high prevalence risks. I have considered the service’s ability to manage high impact and high prevalence risks under Requirements 3(3)(a) and 3(3)(b) above.
* The Site audit report evidenced the service had multiple incidents that had not been reported under the serious incident response scheme within required timeframes, including an incident where a consumer’s wound had become infected with maggots. Staff were unable to demonstrate a shared understanding regarding the serious incident response scheme. Management acknowledged several incidents had not been reported and this would be completed following the Site audit.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* The provider acknowledged that no notification was made for the incident where the consumer’s wound was infected with maggots, and this was subsequently lodged.
* The provider advised for 4 other incidents identified by the assessment team, these were within reporting timeframes and notifications were subsequently completed. Nil information was provided to evidence this.
* The provider advised improvement actions planned or implemented include providing the senior clinical team access to the reporting portal, re-education to all staff on serious incident reporting, and daily review of incidents by service management to ensure timely notification and reporting.

**Assessment**. Having considered the Site audit report and the Provider's response, I find deficiencies in risk management systems and practices for incident identification, management and reporting remain. I have based this decision on the following:

* The provider has not submitted sufficient evidence to demonstrate effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers, and incident prevention and management.
* Improvement actions have not been fully implemented and require time to demonstrate effectiveness and sustainability in ensuring timely identification and reporting of incidents.

I, therefore, find this Requirement non-compliant.

*Requirement 8(3)(e)*

The assessment team brought forward information in the Site audit report to evidence the service’s clinical governance framework has not been effective in monitoring and identifying deficits in the provision of clinical care and management of restrictive practice. The assessment team identified a number of consumers subject to chemical and environmental restraint without appropriate assessment, authorisation, consent, monitoring and review in place in accordance with regulatory requirements.

The provider responded with additional information as outlined under Requirements 3(3)(a) and 8(3)(c) above.

I have considered the information submitted by the assessment team and the provider and am not satisfied the service has submitted sufficient evidence to demonstrate an effective clinical governance framework in place in relation to monitoring and management of restrictive practices, and wound care and management. Improvement actions planned by the service have not been fully implemented and require testing for effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 2 Requirements of Quality Standard 8 are compliant as:

Consumers said the service is well run and they can provide feedback and suggestions to management which is considered. Management described various ways consumers are supported to be engaged in the development, delivery and evaluation of care and services, including via monthly consumer/representative meetings, quarterly surveys, and submission of feedback forms.

The service was able to demonstrate its governing body promotes a culture of safe, inclusive, and quality care and services. Management described how the service conducts monthly quality meetings and submits regular reporting to the Board on clinical and operational risks, which the Board uses to identify the service’s compliance with the Quality Standards, to monitor care and service delivery, enhance performance and mitigate risks.

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)