Performance

Report

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| Name of service: | Blue Haven Bonaira |
| Service address: | 14 Bonaira Street KIAMA NSW 2533 |
| Commission ID: | 0094 |
| Approved provider: | The Council of the Municipality of Kiama |
| Activity type: | Assessment Contact - Site |
| Activity date: | 25 July 2023 to 26 July 2023 |
| Performance report date: | 13 September 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 Haven Bonaira (**the service**) has been prepared by G Cherry, 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 - Site; the Assessment Contact - 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 16 August 2023.
* Performance report dated 28 October 2022

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-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 3(3)(a) – implement an effective system to ensure each consumer receives safe and effective personal/clinical care, which is best practice, tailored to individual needs and optimises health and well-being.
* Requirement 4(3)(f) – implement an effective system relating to meal provision to ensure meals are varied and of suitable quality/quantity.
* Requirement 6(3)(c) – implement effective systems/processes to ensure appropriate action is taken in a timely manner and practices relating to open disclosure implemented in relation to feedback/ complaints.
* Requirement 6(3)(d) – ensure an effective system/process of using feedback and complaints to inform/improve quality of care and services.
* Requirement 7(3)(a) – implement an effective system of workforce planning to ensure the number and mix of staff deployed enables delivery and management of safe/quality care and services.
* Requirement 8(3)(c) – ensure effective organisational wide governance systems relate to information management, continuous improvement, workforce governance and regulatory compliance.
* Requirement 8(3)(d) – ensure effective risk management systems and practices relating to managing high impact/prevalence risks, identify/respond to abuse/neglect and managing/prevent incidents, via use of an effective incident management system.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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 |

Findings

The Quality Standard was not fully assessed; one of six requirements was assessed and found compliant.

A decision was made on 28 October 2022 the service was non-compliant in requirement 2(3)(d) following a Site Audit conducted on 13-16 September 2022 as they did not demonstrate outcomes of assessment and planning are effectively communicated/documented in care plans (particularly relating to changes in care, medication, and incidents) and readily available to consumers. The service’s plan for continuous improvement (PCI) includes provision of staff education; consumers being offered a copy of care plans during review processes (ongoing monitoring to ensure compliance); Registered Nurses conduct a resident of the day (ROD) process including consumer’s representative to discuss changes relating to wellbeing; discussion at consumer/representative and staff meetings regarding availability of care plan documentation.

During this assessment contact information was gathered through interviews, observations, and document review. Document review demonstrate outcomes of assessment/planning are communicated to consumers/representatives and management detailed a proactive approach. Most sampled consumers/representatives consider they are engaged/informed of care needs and care planning documentation is accessible, and management followed through to ensure communication with those who gave feedback to the contrary. Interviewed staff demonstrate awareness of care plan provision to consumers/representatives and specific needs/preferences of individual sampled consumers. The assessment team observe care plans accessible to staff and a process ensures availability to consumers/representatives.

In consideration of compliance, I am swayed by the volume of consumer/representative satisfaction, processes demonstrated by management/staff and management’s immediate responsiveness by management to feedback received. I find requirement 2(3)(d) 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:   * is best practice; and * is tailored to their needs; and * optimises their health and well-being. | Non-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 Quality Standard was not fully assessed; two of seven requirements were assessed, and one found non-compliant.

A decision was made on 28 October 2022 the service was non-compliant in requirements 3(3)(a) and 3(3)(g) following a Site Audit conducted on 13-16 September 2022.

Requirement 3(3)(a)

Previously the service was found non-compliant as they did not demonstrate an effective process to ensure each consumer receives safe/effective personal and clinical care relating to principles of best practice, tailored to individual needs to optimise health and well-being. The service’s plan for continuous improvement (PCI) includes education forums and staff meetings used for provision of education on topics of immediate concern (such as restrictive practices, care plan directives; implementation of purposeful observations and discussions relating to consumer’s needs, review of handover discussions/documentation to ensure consumer changes communicated to all staff. During this assessment contact information was gathered through interviews, observations, and document review.

An effective system to ensure consumers’ personal/clinical care is as per best practice principles, tailored to individual needs and optimises health/well-being is not evident. Some sampled consumers/representatives gave positive examples relating to consumer’s care, and satisfaction relating to staff knowledge, others express concerns relating to lack of care provision. The assessment team observed consumers not receiving appropriate clinical care. Via interview with consumers/representatives, management and staff, plus review of several sampled consumer documentation, the assessment team note lack of appropriate clinical care relating to wound and pain management, food/fluid monitoring, unplanned weight loss, hospital directives relating to equipment requirements post fall/fracture, lack of appropriate hygiene care/equipment to maintain skin integrity, lack of documented informed consent relating to psychotropic medications and lack of information/directives within behaviour support plans (BSP’s) to guide care delivery. While senior clinician interview advised directives in relation to required equipment had not been supplied for one consumer (due to identification of falls risk) demonstration of alternative treatment/support is not evident. Management acknowledges pressure injury management not reflective of best practice and lack of required food/fluid intake management, lack of regular review relation to psychotic medications advising planned provision of staff education/training. In addition, they acknowledge BSPs had not been developed until recently and delirium screening for consumers experiencing changed behaviours and falls is required. While management note a recent reduction in psychotropic medication usage the assessment team note risk assessments and informed decision-making processes not consistently demonstrated in relation to all restrictive practices.

In their response, the approved provider acknowledges lack clinical care provision however supplied supporting documentation negating some evidence bought forward by the assessment team. They note a period of significant change, turnover of management team impacting stability/growth. While noting some recent improvement activities have occurred since the assessment contact visit, they commit to strengthening processes and implementing effective oversight due to commencement of an independent clinician, engagement of external subject matter experts to support reduction of restrictive practices, provision of staff education/training, plus engagement of a lifestyle consultant to ensure provision of meaningful consumer engagement and non-pharmacological interventions. In addition, a committee of clinicians, medication officers, specialists and pharmacy representatives is planned to regularly review/assess complex cares and consumers identified as high risk. In consideration of compliance, while noting the approved providers commitment to implement processes to attain compliance, I am swayed by the evidence bought forward by the assessment team and consider it will take some time to ensure sustainability/effectiveness of newly implemented actions and staff education/training. I find requirement 3(3)(a) is non-compliant.

Requirement 3(3)(g)

Previously the service was found non-compliant as they did not demonstrate an effective system to minimise infection related risks via implementing appropriate precautions to prevent/ control infection or practices promoting appropriate antibiotic prescribing/use to support optimal care and reduce risk of antibiotic resistance. The service’s plan for continuous improvement (PCI) includes provision of education and conducting staff competencies in relation to infection control practices and Registered Nurse resources relating to this topic, appointment of a new infection control/prevention (IPC) lead, and another enrolled in the course. The assessment team note the outbreak management plan did not incorporate management guidelines relating to influenza, gastroenteritis, and scabies, as outlined in the PCI provided to the Commission, which management acknowledged and advised planned completion. During this assessment contact information was gathered through interviews, observations, and document review.

An organisational suite of policies/procedures guide expectations and directives relating to infection control/minimisation and antimicrobial stewardship. Effective practices minimise spread of infection and consumer documentation demonstrate appropriate intervention. Staff described strategies to minimise infection and demonstrate understanding of antimicrobial stewardship and processes relating to outbreak management. Organisational systems include an outbreak management plan and management personnel detailed processes to minimise spread of infection when closure of the service is required. Sampled consumers/representatives express positive feedback regarding management of infections and practices used in relation to outbreak prevention/management. I find requirement 3(3)(g) is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard was not fully assessed; two of seven requirements were assessed and one found non-compliant.

A decision was made on 28 October 2022 the service was non-compliant in requirements 4(3)(f) and 4(3)(g) following a Site Audit conducted on 13-16 September 2022.

Requirement 4(3)(f)

Previously the service was found non-compliant as they did not demonstrate an effective system of meal provision, to ensure variety and suitability of quality and quantity. The service’s plan for continuous improvement (PCI) includes a dietitian to review menus to ensure nutritional needs are met, provision of food safety/infection control education to Hospitality manager, food forums to be conducted, review of roster to facilitate catering staff availability for meal service and provision of education relating to meal service/presentation.

During this assessment contact information was gathered through interviews, observations, and document review. Sampled consumers/representatives expressed mixed feedback regarding meal provision. Some gave positive feedback, including availability of options; others expressed dissatisfaction regarding consistency of meals, dislike of planned meal choice (acknowledging options available), meal presentation, experiencing unplanned weight loss and provision of meals containing ingredients of allergy/intolerance. Most acknowledge the new management team’s effort in achieving improvement and several advised sourcing foods to supplement inedible meal service. Management and dietitian interview resulted in explanation of challenges faced and changes implemented to attain consumer satisfaction regarding quality of meals, including a range of additional available snacks and new in-house service enabling increased autonomy to meet consumers’ needs/wishes. Documentation review detailed multiple actions taken to address dissatisfaction. Dietitian review of menu planning occurs to ensure appropriate nutritional requirements and quality.

In their response, the approved provider acknowledges issues relating to meal delivery citing changed improvement due to new management team and trial implementation of changes, however, acknowledge ongoing issues relating to consumer dissatisfaction. They advise recent changes to meal service delivery, meeting forums overseen by clinical staff/allied health specialists and social companion programs aimed to stabilising unplanned weight loss as methods to achieve satisfaction/compliance. In consideration of compliance, while noting the approved providers progress and commitment to further planned changes/improvements, I am swayed by the evidence bought forward by the assessment team and consider it will take some time to ensure sustainability/effectiveness of newly implemented actions. I find requirement 4(3)(f) is non-compliant.

Requirement 4(3)(g)

Previously the service was found non-compliant as they did not demonstrate an effective system to ensure provided equipment is safe, suitable, clean, and well maintained. The service’s plan for continuous improvement (PCI) includes provision of staff education relating to reporting equipment needs, topic added to meeting forums and discussion at staff meetings, monitoring of equipment to ensure appropriate quality/quantity, addition supplies of equipment for immediate use when needed.

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives consider appropriate quantity/quality of equipment, including purchase of specific equipment to suit personal needs/comfort/safety and effective processes to ensure cleanliness/well-maintained equipment. Interviewed staff note sufficient equipment to do their job, management team supportive of new purchases when required and maintenance staff explained processes to ensure equipment remains in good working condition. Observations by the assessment team note a range of equipment to support consumers’ needs. I find requirement 4(3)(g) is 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The Quality Standard was not fully assessed; two of four requirements were assessed and found non-compliant.

A decision was made on 28 October 2022 the service was non-compliant in requirements 6(3)(c) and 6(3)(d) following a Site Audit conducted on 13-16 September 2022.

Requirement 6(3)(c)

Previously the service was found non-compliant as they did not demonstrate appropriate action is taken in response to complaints nor an open disclosure process used when things go wrong. The service’s plan for continuous improvement (PCI) includes provision of staff education, review of recording documentation to align with organisational policy/procedure and review of prior meeting minutes to ensure all feedback/complaints are recorded on monitoring documentation, plus management team attendance at consumer forums to provide feedback on matters raised.

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives consider they are comfortable in providing feedback/compliant when required, and several consumers/representatives who have made a complaint express mixed feedback relating to their experience and/or resolution. Four expressed satisfaction of outcome resolution (one noting a lack of apology received), and four noted dissatisfaction, lack of resolution in relation to meal service, lack of meaningful activities and equipment not working. Management described recently implemented processes including working collaboratively with complainants to achieve resolution, noting awareness of some ongoing consumer dissatisfaction. Documentation review detail changes in recording/monitoring processes including comprehensive detail, prompts regarding ongoing evaluation/effectiveness of actions to ensure satisfactory outcome/resolution.

In their response, the approved provider acknowledges feedback/complaints not effectively managed in a timely manner citing confidence recent changes in management personnel will result in positive outcomes. They advise new management personnel monitor recent processes changes to ensure improved outcomes, with supporting evidence to demonstrate progress to date. In consideration of compliance, while noting the approved providers progress and commitment to further planned changes/improvements, I am swayed by the evidence bought forward by the assessment team and consider it will take some time to ensure sustainability/effectiveness of newly implemented actions. I find requirement 6(3)(c) is non-compliant.

Requirement 6(3)(d)

Previously the service was found non-compliant as they did not demonstrate feedback and complaints are reviewed and used to improve quality of care and services. The service’s plan for continuous improvement (PCI) includes organisational quality/compliance manager monitoring trends and supporting service management with continuous improvement activities, auditing complaints documentation/responses to ensure compliance with organisational policy/procedure; topic discussed at meeting forums and review policy/procedure to ensure availability of comprehensive guidelines.

During this assessment contact information was gathered through interviews, observations, and document review. Sampled consumers/representatives provided mixed feedback relating to a link between feedback/complaints and improvement activities. Some consider they have a say in how things work, acknowledging new management personnel working towards improved outcomes, and some improvement relating to meals. However, others note lack of satisfactory outcome relating to feedback, non-involvement in feedback processes as while they feel listened to, they don’t believe satisfactory outcomes result. Management detail knowledge of main topics relating to consumer/representative complaints and documentation detail recognition of improvement in many areas of care and service delivery.

In their response, the approved provider acknowledges feedback/complaints not effectively managed in a timely manner citing confidence recent changes in management personnel will result in positive outcomes. They advise new management personnel monitoring recent processes changes to ensure improved outcomes, with supporting evidence to demonstrate progress to date, including changes to lifestyle programs. In consideration of compliance, while noting the approved providers progress and commitment to further planned changes/improvements, I am swayed by the evidence bought forward by the assessment team and consider it will take some time to ensure sustainability/effectiveness of newly implemented actions. I find requirement 6(3)(d) is non-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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Quality Standard was not fully assessed; two of five requirements were assessed, and one found non-compliant.

A decision was made on 28 October 2022 the service was non-compliant in requirements 7(3)(a) and 7(3)(e) following a Site Audit conducted on 13-16 September 2022.

Requirement 7(3)(a)

Previously the service was found non-compliant as they did not demonstrate systems to ensure a planned workforce, and the number/mix of staff enables delivery and management of safe/quality care and services. The service’s plan for continuous improvement (PCI) includes ongoing recruitment of key personnel including strategies for ongoing workforce planning including partnership with technical/further education institution, registered training organisations, universities, implementing specific recruitment days, implementation of a new graduate RN program, review of response times to identify/investigate delays in response time and review of rostering processes.

During this assessment contact information was gathered through interviews, observations, and document review. Sampled consumers gave mixed feedback regarding staffing levels. Most consumers/representatives consider numbers and mix of staff is not adequate to meet consumers’ needs/preferences. Examples include insufficient staff to ensure hygiene needs are met in the morning prior to breakfast, assist with serving of breakfast, lack of timely response relating to continence needs, staff not knowing consumer’s food allergies resulting in receipt of incorrect meals, non-attendance at activities, lack of skilled staff regarding meal delivery and to assist consumer’s mobility needs. Interviewed staff generally consider they can complete required duties on most occasions, noting while management do not actively work to replace staff when unplanned leave occurs, re-allocation of staff/responsibilities occurs via RN’s discretion/guidance. Processes to ensure a planned workforce/sufficient staff numbers were demonstrated and management explained current modifications to improve systems alerting staff to consumers quests for assistance, plus increase in lifestyle staff to implement activities program on weekends. However, the assessment team note deficits in staff knowledge and the delivery/management of safe quality care and service [considered in requirement 3(3)(a)].

In their response, the approved provider acknowledges ongoing challenges relating to workforce planning and delivery of care however refutes concerns relating to numbers of staff, attributing perception of a reduced workforce due to the service design layout. They advise of changes to system of alerting staff to consumers’ needs/monitoring of same and establishing links with community education services/implementation of traineeships as a means of workforce retention. In consideration of compliance, while noting the approved providers commitment to seeking innovative means of reducing recruitment barriers and increase workforce retention, I am swayed by the evidence bought forward by the assessment team. I find requirement 7(3)(a) is non-compliant.

Requirement 7(3)(e)

Previously the service was found non-compliant as they did not demonstrate systems to ensure regular assessment, monitoring and performance review occurs regarding each member of the workforce. The service’s plan for continuous improvement (PCI) includes review of monthly reports relating to completion of performance assessment reviews and facilitation of continuity; human resource department to provide support with non-compliance and/or performance issues and organisational management to monitor ongoing processes. During this assessment contact information was gathered through interviews, observations, and document review. Interviewed human resource personnel explained processes relating to staff appraisals occurring with supervisors to review performance and a monitoring process to measure completion when circumstances prevent discussion/meeting processes. Via review of incident reporting documentation, the assessment team note processes to manage underperformance and staff receive informal coaching/feedback when required. I find requirement 7(3)(e) 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)(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 |

Findings

The Quality Standard was not fully assessed; three of five requirements were assessed and two found non-compliant.

A decision was made on 28 October 2022 the service was non-compliant in requirements 8(3)(a) and 8(3)(c) following a Site Audit conducted on 13-16 September 2022.

Requirement 8(3)(a)

Previously the service was found non-compliant as they did not demonstrate an effective system to ensure consumers are supported to engage in the development, delivery and evaluation of care and services. The service’s plan for continuous improvement (PCI) includes reviewing ROD process to encourage partnering in care, management personnel attending meeting forums to provide feedback to attendees on matters raised; engagement of recreational activity officer (RAO) in feedback surveys; organisational quality/compliance manager engaging representatives through satisfaction surveys and identifying consumer advocates and review of survey results/development of reports to inform continuous improvement activities. During this assessment contact information was gathered through interviews, observations, and document review. Interviewed management personnel detail consumer engagement incorporated across various areas of service delivery. The Chief Executive Officer (CEO) and Chief operating officer (COO) advise an organisational community engagement strategy guides/informs strategic and operational planning, including specific projects/initiatives and formally reports on progression in achieving outcomes/objectives. Review of documentation detail further plans to enhance consumer engagement. Sampled consumers/representatives consider they have input into what happens at the service, and most felt comfortable in providing feedback acknowledging management and staff listen to what they have to say. Some acknowledge improvements in response to feedback, however others note feedback not yet actioned. The assessment team note an increased involvement/responsiveness to feedback, including management attendance at meeting forums resulting in a pro-active approach in complaint resolution and seeking consumer feedback/satisfaction/involvement in development/delivery of outcomes. I find requirement 8(3)(a) is compliant.

Requirement 8(3)(c)

Previously the service was found non-compliant as they did not demonstrate effective organisation wide governance systems relating to information management, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints management. The service’s PCI includes executive team addressing Council in relation to board re-election and service’s financial position, senior management maintaining continuous improvement processes including internal auditing and review/escalation of critical incidents, regular review/staff discussion relating to clinical indicator data, provision of education regarding quality benchmarking program and development of workforce retention strategy. During this assessment contact information was gathered through interviews, observations, and document review. The CEO explained recent dis-banding of board members resulted in Council members becoming the governing body with responsibility to assist in maintaining inclusive and culturally safe/quality care and ensure compliance with regulatory frameworks. Strategies/plans, policy and procedures exist in relation to some aspects of this requirement however do not provide guidance in relation to organisational expectations/directives to ensure overall compliance. Effective overarching processes are evident in relation to information management, financial and workforce governance and feedback/complaints. Information is provided to Council and aged care advisory committee via reporting mechanisms; review of reports from 2023 demonstrate escalation of some complaints to the Commission and trending relation to meal delivery.

An organisational risk management framework with policy guidance exists for whole of Council; including an audit/risk and improvement committee. The CEO explained organisational support for the risk management functions and an enterprise-wide risk register includes broad strategic risk categories relevant to the aged care portfolio. A quality benchmarking program is used for ongoing self-assessment of service performance to identify opportunities for systemic improvement. Reports to Council demonstrate the governing body is broadly informed about continuous improvement activities and progress. However, while development of a PCI occurred in relation to previous non-compliance with the Quality Standards, demonstration of effective processes to drive timely/sufficient improvement is not evident. The decision is the service is non-compliant in 7 requirements of the Quality Standards. The COO and manager of people/performance detailed workforce governance. However, effective organisation wide governance systems are not evident in relation to continuous improvement and regulatory compliance. Demonstration that restrictive practices are used as a last resort and care staff knowledge of Behaviour Support Plans (BSPs) as a source of guidance to provide effective behaviour support is not evident (considered within requirement 3(3)(a)].

In their response, the approved provider acknowledges evidence bought forward by the assessment team, noting a recent period of significant change and turnover of management team impacting stability/growth. While noting some recent improvement activities have occurred since the assessment contact visit, they commit to strengthening processes and implementing effective oversight due to commencement of an independent clinician and engagement of external subject matter experts to support reduction of restrictive practices and provision of staff education/training. In consideration of compliance, while acknowledging the approved providers commitment to implement processes to attain compliance, I am swayed by the evidence bought forward by the assessment team. I find requirement 8(3)(c) is non-compliant.

Requirement 8(3)(d)

A draft risk management framework specific to aged care portfolio is in development and currently includes some elements relating to a risk management framework. Management personnel explained the integration of strategic and operational risk management systems. Service-related risk management policy/procedures detail various high impact/prevalence risks associated with consumer’s care, such as changed behaviours, dysphagia, falls and nutrition and the assessment team note plans to review operational risks/management. Reports to the governing body and aged care advisory committee include some data relating to high impact/prevalence risks such as chemical restraint, falls, pressure injuries/ wounds, and unplanned weight loss however, the assessment team note inaccurate data provision [considered in requirement 3(3)(a)]. Policy and procedure documentation details expectations relating to preventing consumer abuse and neglect and the assessment team note reporting to relevant regulatory bodies. Incident reports detail trends. Policy and procedures regarding prevention and management of incidents exists. Interviewed staff did not demonstrate awareness of BSPs relating to individual consumer’s needs and BSPs did not include all required information. The assessment team note evidence psychotropic medications were not utilised as a last resort and incident data not consistently reported relating to falls. The COO explained processes for reporting/escalating consumer incidents including when serious/critical incidents occur however note required improvements as reporting mechanisms do not consistently detail relevant information. The assessment team bought forward evidence that while the CEO note plans to enhance governing body oversight of aspects relating to this requirement, effective governance systems/practices relating to managing high impact/prevalence risk, identifying/responding to abuse/neglect, managing/preventing incidents, including use of an effective incident management system are not currently evident.

In their response, the approved provider acknowledges deficits in compliance, noting a period of significant change due to turnover of management team members impacting stability/growth requiring ongoing organisational support by Quality and Governance personnel. While disputing some aspects in relation to reporting to regulatory authorities they commit to strengthening reporting and implementing effective oversight due to commencement of an independent clinician. In consideration of compliance, while noting the approved providers commitment to implement processes to attain compliance, I am swayed by the evidence bought forward by the assessment team. I find requirement 8(3)(d) is non-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)