Performance

Report

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| Name: | Booroongen Djugun Limited |
| Commission ID: | 0457 |
| Address: | 337-351 River Street, GREENHILL via KEMPSEY, New South Wales, 2440 |
| Activity type: | Site Audit |
| Activity date: | 20 August 2024 to 22 August 2024 |
| Performance report date: | 9 October 2024 |
| Service included in this assessment: | Provider: 1399 Booroongen Djugun Limited  Service: 473 Booroongen Djugun Limited |

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 Booroongen Djugun Limited (**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 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 19 September 2024.

# 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 | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 3(3)(b) - Implement effective management of high impact/prevalence risks associated with each consumer’s care, in particular relating to smoking within the building and those requiring oxygen therapy. Implement an effective monitoring system to ensure ongoing adherence with risk mitigation strategies.
* Requirement 5(3)(b) – Implement an ongoing effective system to ensure a safe, clean, well- maintained, and comfortable service environment, in particular to risks relating to consumers smoking within the building, plus an effective monitoring system to ensure ongoing compliance.
* Requirement 5(3)(c) – Develop a system to ensure furniture, fittings, and equipment are safe, clean, well-maintained, and suitable for consumer use, plus an effective monitoring system to ensure ongoing compliance.
* Requirement 8(3)(c) – Implement an effective organisational governance systems relating to the following information management, continuous improvement, financial and workforce governance, regulatory compliance, and feedback/complaints, plus an effective monitoring system to ensure ongoing compliance.
* Requirement 8(3)(d) – Implement effective risk management systems and practices, relating to management of high impact/prevalence risks (in particular consumers who choose to smoke), and preventing/managing incidents, via use of an incident management system. Implement an effective monitoring system to ensure ongoing adherence with risk mitigation strategies.
* Requirement 8(3)(e) – Implement an effective clinical governance framework relating to antimicrobial stewardship, minimising restraint use and open disclosure, including a monitoring system to ensure ongoing compliance.

# Other relevant matters:

Booroongen Djugun is a 60-bed service comprised of a secure nursing home, general nursing home and individual low care hostel units/rooms located in Kempsey, New South Wales. At the time of the audit 56 consumers reside at the service. The environment supports Indigenous and non-indigenous consumers, appears welcoming and gives consumers the opportunity to freely move throughout. There is a mixed cohort of consumers, many receiving National Disability Insurance Scheme (NDIS) funding and support programs. The governing body has a new chief executive officer (CEO).

# 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

Interviewed consumers and representatives consider consumers are treated with dignity, respect and their identity, culture and diversity valued. Positive feedback includes respecting ‘sorry business’ and assisting consumers to attend ceremonies/funerals of importance. Documents reflect consumer’s diversity, including information about cultural beliefs and preferences. Staff were observed respectfully interacting and demonstrating familiarity with consumer’s backgrounds. Policies outline expectations of treating consumers with dignity and respect.

The service demonstrates provision of culturally safe care and services. Information relating to consumers’ life history including cultural/spiritual needs is captured in care planning documentation. Consumers/representatives gave positive feedback the service meets their cultural needs. Staff demonstrate knowledge of consumer’s culture influencing care delivery. Interviewed consumers and staff described the service facilitating a smoking ceremony when an indigenous consumer dies enabling their spirit to leave. Staff were observed respecting consumers culture of referring to elders by their preferred title of Aunty and Uncle. Consumers/representatives express satisfaction of consumers being supported to exercise choice, maintain independence and relationships of importance. Staff explained support includes overnight stays to visit family members and respecting consumers choice to not have assistance with personal care.

Processes ensure consumers are supported to live the best life they can and take appropriate risk. Assessments are completed to support consumers who undertake some activities of risk and where appropriate, associated mitigation strategies exist to provide support. Examples include supporting 2 consumers to return to live in their home and independent hostel living environment. Comprehensive risk assessments and mitigation strategies including geriatrician review/assessment, occupational therapy assessment/organisation of a homecare package/ agreement for a trial period. Consumers express satisfaction of support received relating to their choice. However, the assessment team note risk mitigation strategies for consumers smoking in their rooms and/or when using oxygen have not been implemented [refer requirements 3(3)(b), 5(3)(b) and 8(3)(d)].

Information is provided to consumers via a range of methods. Consumers express satisfaction information enables them to make choices, stating information is clear and easy to understand. Documents and posters were observed on display; including activity program, internal and external complaints mechanisms; advocacy services; meal options and advice of site audit visit. The service demonstrates consumer’s privacy is respected, and personal information confidentially maintained and consumers/representatives’ express satisfaction of this. Staff describe practical methods of respecting consumers privacy and were observed doing so when delivering care and confidentiality when accessing the electronic care planning system. Policies guide staff relating to service expectations.

# 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

A process of assessment and planning considers risk to consumer’s health and wellbeing to inform delivery of safe, effective care and services. Consumers and representatives consider receipt of appropriate care and services. Staff describe how assessment and care planning inform individual care and documents demonstrate consideration of risk. Interim care plans are developed when consumers first enter the service, after which staff complete comprehensive assessments/care plans. Competency assessments are conducted for those consumers who choose to self-administer medications and record blood glucose levels (BGL’s). Reassessment occurred for a consumer after experiencing a fall resulting in mobility changes. Policies and procedures support staff in assessment and planning completion. However, the service did not demonstrate effective consideration of risk for consumers who smoke cigarettes indoors (refer requirements 3(3)(b), 5(3)(b) and 8(3)(d).

A review of clinical files demonstrates assessment and planning reflect individual needs/preferences. While documented goals are clinically based, care planning reflects consumer’s preferences and how they choose to live. Advance care directives and/or end of life discussions occur during admission processes, regular care conference meetings/reviews and outcomes are documented for most consumers.

The service demonstrates partnering with consumers, and others they wish involved in assessment/planning of care. Documents evidence regular reviews/evaluations plus involvement of a diverse range of external providers, including medical officers, physiotherapists, dietitians, speech pathologists, NDIS support workers and senior behaviour support practitioners. Consumers and representatives note involvement/satisfaction with this process. Staff explained how they actively collaborate with consumers, representatives, and other providers of care to ensure quality care provision. One consumer described discussion with a registered nurse regarding planned care including wound treatment and risks. One representative expressed satisfaction in staff supporting their consumer and being informed when changes occur. Another representative considers appropriate involvement in care including receipt of a documented care plan for review. Outcomes of assessment and planning are effectively communicated to consumers/representatives and documented in an electronic care planning system. Consumers and representatives consider Management and staff maintain communication, particularly relating to changes in care/medication, and staff clearly communicate clinical matters. Clinical staff advise representatives are contacted via telephone and/or email. Three representatives confirm discussions relating to their relative’s care and received a copy of care plans. The care manager/acting facility manager and clinical lead advise consumers/representatives have access to a detailed care plan.

Overall, documents evidence regular review and/or when circumstances change, including incidents and identification of deteriorating condition. Management and clinical staff demonstrate the process for review and consumer/representatives’ express satisfaction clinical staff regularly discuss care. Documents for one consumer detail referral to a senior behaviour support practitioner for review because of an incident and subsequent recommendations detailed to guide staff in care delivery. Another consumer’s documents detail reassessment post fall, directives to guide staff resulting in a reduction in falls. Assessment and care planning policies/procedures guide review, including staff responsibility to ensure documents reflect consumer’s current needs. Document demonstrates inconsistent completion of incident forms to identify/address root cause analysis to ensure implementation of strategies to mitigate recurrence (acknowledged by Management).

# 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. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission-based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirement 3(3)(b) - The assessment team bought forward evidence of deficits in management of high impact/prevalence risks associated with consumers smoking in their rooms, and/or when receiving oxygen therapy, not within designated smoking areas. The care manager/acting facility manager and clinical lead demonstrate awareness of the service’s main risk includes consumers smoking. Management advised 15 consumers smoke in their rooms. Staff advised awareness of consumers smoking in their rooms, and the CEO advised incident reports are required however this was not consistently occurring. The assessment team bought forward evidence of a lack of clinical incident/critical incident review when incident forms are completed.

The service does not demonstrate effective management/mitigation of individual consumer risks nor for all consumer residing at the service. The assessment team raised evidence (11 months prior) of two consumers smoking in rooms resulted in CEO commitment to introduce effective risk management strategies to ensure consumer safety. The service now has an increase from 2 to 15 consumers smoking in rooms without demonstrating evidence of effective risk management strategies, including one consumer smoking while using oxygen resulting in significant concerns for their safety (and other consumers) due to smoking risks not effectively managed. In response, Management provided consumers with a letter of intent to immediately cease smoking in rooms/inside buildings, plus planned notification to NDIS providers who support NDIS consumers. The CEO met with consumers informing of the designated smoking area.

In the provider’s response, they supplied evidence of contacting consumers regarding changes/adherence to smoking requirements/regulations, reassessment of individual risk, written notification from the Board to relevant consumer’s, staff monitoring of consumer’s rooms, meeting forums, and analysis of reported incidents. While a reduction of incidents where consumers are identified as smoking in rooms has occurred, compliance is not achieved.

While acknowledging the provider’s immediate and subsequent actions, I am concerned although having an awareness consumers were smoking in their room, the organisation did not implement monitoring/preventative actions to ensure safety and compliance. In addition, I am cognisant the provider’s previous commitment to attain compliance was not successfully implemented resulting in a substantial increase in numbers of consumer’s smoking within the building environment. I find requirement 3(3)(b) is non-compliant.

The remaining requirements are compliant.

Overall, the service demonstrated consumers receive personal and clinical care tailored to individual needs, optimising health, and well-being. Interviewed consumers/representatives’ express satisfaction with care. Staff demonstrate knowledge of individual consumers care and how they ensure care is tailored specific to needs. Documents detail appropriate clinical care including consumers living with diabetes having blood glucose levels (BGL) monitored in line with directives and effective management of ‘as needed’ (PRN) medication. For consumers living with a long-term catheter care (for management of renal concerns and/or incontinence), documents demonstrate appropriate management. A review of wound management documents demonstrate RNs attend wound care however do not include evidence of wound photography/measurements to monitor wound healing/progression. While the service’s policy requires staff to regularly photograph wounds to support evidence of healing progress, Management advised a lack of measuring equipment prevented this. The provider’s response detailed purchase of measuring equipment. Review of one consumer living with chronic wounds demonstrates improvement in wound healing and this consumer expressed satisfaction with care. Processes exist for use of restrictive practices and psychotropic medication and the care manager/acting facility manager and clinical lead are responsible for maintaining oversight. Documents detail information relating to prescribed medications, informed consent, and a behaviour support plan (BSP) guides staff in required care. Sampled consumers/representatives consider staff meet consumers personal hygiene needs and personal care is tailored to specific needs. Evidence relating to changes in hygiene care resulted in improved skin integrity for one consumer.

Documents for sampled consumers nearing end of life demonstrate care needs/preferences have been identified and actions implemented to address these. Their wishes and directives (advance care/end of life/case conference) are incorporated into care plan directives to guide care delivery. The service ensures a substitute decision-maker (where possible) is identified and documented. Consultation occurs with consumers and representatives when a referral to palliative care is required and/or when a consumer commences on a palliative pathway/nearing end stage of life. Review of one consumer’s documents detail care requirements and family in attendance. Medical notes demonstrate maintaining comfort a priority with a medication regime for comfort/pain management administered by staff and regular medical officer review. Interviewed staff demonstrate awareness of current care needs and wishes.

The service demonstrates consumers who have experienced a deterioration or change in cognition, condition, function, and/or mental health have their needs recognised and responded to in a timely manner. Registered nurses liaise with care manager/acting facility manager or clinical lead/medical officer and consultation with consumers/representatives occur. For sampled consumers, documents reflect identification and response. One consumer experiencing altered physical sensation was reviewed by paramedics directing staff monitoring and medical officer notification. Increased pain resulted in subsequent clinical review/monitoring, review by a geriatrician and speech pathologist in relation to changed condition and symptoms. The consumer expressed satisfaction with treatment and staff monitoring of care. A process communicates consumer's condition, needs and preferences within the organisation and others responsible for care via an electronic care program, referral system, and communication. A verbal handover between shifts communicates matters for staff attendance. Appointments and specific requirements are documented to enable transfer of information to all responsible for care. Consumers and representatives’ express satisfaction regarding communication of care needs.

Care planning documents for sampled consumers evidenced input of others such as allied health professionals, medical officers, and specialists and evidence of referrals exists. Specialist and allied health professional input/directives are documented in consumers’ clinical files. For example, one consumer’s documents demonstrate referral to a wound specialist on multiple occasions and referral to an infection specialist for commencement of long-term antibiotics resulting in improved care and evidence of wound healing. Another consumer living with Parkinsons disease was referred to neurologist due to increased tremors and for consumers receiving NDIS services documents evidence timely referrals to support behavioural needs.

Clinical Management team members and RNs demonstrate an understanding of antimicrobial stewardship, principles for outbreak management and standard precautions. An outbreak preparedness/management plan and associated documents guide staff practice. There is an infection prevention control lead (IPC lead) and a surveillance system to record infections. Registered staff request the medical officer to order pathology prior to commencing antibiotics. A process exists for consumers to receive COVID-19 and influenza vaccinations post consent, and antiviral medications are available. Staff were observed practicing appropriate hand hygiene washing. Consumer documents detail infections and preventative measures to mitigate risk of reoccurrence.

# 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

Sampled consumers and representatives consider consumers are supported to participate in activities they like and provided with appropriate support to optimise independence and quality of life. They express positive feedback relating to recreational activities, and support to do things of interest. Interviewed lifestyle and clinical/care staff demonstrate awareness of consumers’ preferences/needs, explaining individual consumer’s needs aligned with documentation. Consumers (of varying levels of ability) were observed engaged in daily living activities. The service has created an area (within the communal room) to support one consumer’s activity of choice whilst interacting with others. Staff support another consumer (unable to independently ambulate) to attend outings with a support worker. Consumers advise enjoyment of services/supports offered via the lifestyle program, citing bus trips, one-on-one outings, bingo, and yarning around the fire pit.

Consumers and representatives consider consumers emotional and spiritual needs are met, expressing satisfaction with staff’s caring/supportive manner. Systems support spiritual needs including referral to appropriate services for other supports when needed. Individual needs are documented to guide staff. Two consumers are supported to view church services via an electronic streaming program plus regular visits from church members. Consumers gave examples of an Aboriginal smoking ceremony regularly performed by an elder of the community. Consumers are supported to maintain contact with those of importance, noting visitors feel welcomed when visiting the service. Consumers express satisfaction of support to do things of interest within the service and in the community. They were observed sitting around a large rotunda with firepit socialising and sharing stories. The lifestyle staff described the process for scheduling activities including consumer involvement in planning.

Consumers/representatives consider information regarding daily living, choice/preferences are effectively communicated and staff providing daily support understand needs. Care documents provide appropriate information to support effective and safe sharing of information. Representatives consider staff keep them informed. Staff advise they are informed of changes through communication with an RN during shift handover processes and documents. Catering staff demonstrate how clinical staff communicate dietary changes noting dietary information is updated via the electronic care system and visual alerts in the kitchen. Timely and appropriate referrals to other organisations, individuals and providers of care/services is evident. Documents demonstrate evidence of collaboration with external providers to support consumers diverse needs, including Dementia Support Australia, hairdressers, audiologists, NDIS, and spiritual leaders. Interviewed consumers/representatives considers the service supports consumers receiving NDIS services and ensure they receive required support. Meals (prepared on site) are varied and of suitable quality/quantity using a seasonal menu developed with consumer input and reviewed by a dietician. Most consumers gave positive feedback regarding taste, variety, and sufficiency. Consumers and staff consider lifestyle equipment is safe, suitable, and clean. The assessment team observed a range of equipment including lifters, slings and activity equipment appeared to suitable, clean, and in good condition. A system ensures equipment is regularly cleaned and staff consider access to appropriate equipment/resources, plus a reporting processes exist for maintenance/repair work.

# 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. | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings, and equipment are safe, clean, well maintained, and suitable for the consumer. | Not Compliant |

Findings

Requirement 5(3)(a) - The service environment includes 3 sections, a secured nursing home, general nursing home and hostel with single rooms, ensuites and some shared bathrooms. Hostel units are individual units with bathroom/kitchenette and each unit has an outdoor area. The service appears welcoming with indoor communal areas and outdoor garden areas, a rotunda with firepit, plus a water pond (billabong) situated behind the service. Consumers were observed in communal areas and the rotunda. A wellness centre offers a variety of lifestyle activities. Consumers were observed moving throughout the service using a range of mobility assistive equipment, including electric scooters, wheelchairs, and wheeled walkers. They consider the environment is welcoming to them and family/friends, they feel at home and the service optimises a sense of belonging.

Requirement 5(3)(b) - The service environment enables most consumers to freely move indoors and out, accessing gardens and entrance to the service. The secured environment has access to garden courtyards for consumers residing in this area. Via observation, the assessment team bought forward evidence the environment did not present as safe, clean, or well-maintained due to lack of cleaning. Observations include:

* The walls/doors in communal areas and consumer rooms were unclean, missing paint
* The kitchenette, consumer’s rooms, windows were unclean/cobwebs on windows
* Carpeting in some hostel rooms is worn and marked
* The dining room floor contained dirt along wall edges and under furniture
* Airconditioning units contained dirt in the vents
* Cigarette butts were littered throughout the outdoor environment
* Garden areas not to be well maintained.

An environmental audit conducted four months prior identified the service to be unclean. Management acknowledged the environment required a detailed clean and review of garden/landscaping contractors. They advised planned sourcing of an external cleaning company and internal staff responsible for ongoing maintenance, plus review of financial grant opportunities.

Demonstration of an effective system to ensure consumers who choose to smoke do so within a designated smoking area is not evident. Management and staff advised awareness of 15 consumers who smoke in their rooms. The service does not demonstrate effective management/mitigation of individual consumer risk nor risk to all consumers residing at the service to ensure safety. The assessment team raised evidence (11 months prior) of two consumers smoking in rooms resulted in CEO commitment to introduce effective risk management strategies to ensure consumer safety. Evidence now details an increase from 2 to 15 consumers smoking in rooms, including one consumer smoking while using oxygen resulting in significant concern for their (and other consumers’) safety. In response, Management provided consumers with a letter of intent to immediately cease smoking in individual rooms/inside buildings, plus planned notification to NDIS providers who support NDIS consumers living at the service. The CEO met with consumers informing of the designated smoking area.

In response to lack of a safe environment, the provider supplied evidence of contacting consumers regarding changes/adherence to smoking requirements/regulations, reassessment of individual risk, written notification from the Board to relevant consumer’s, staff monitoring of consumer’s rooms, meeting forums, and analysis of reported incidents. While a reduction of incidents where consumers are identified as smoking in rooms has occurred, compliance is not achieved. In response to a lack of a clean, well maintained, comfortable environment, the provider advised of seeking quotes from an external supplier to assist with cleaning and garden maintenance, plus recruitment of internal cleaning staff, development of cleaning schedules and regular meeting forums.

While acknowledging the provider’s actions, I am concerned although having self-identified cleaning issues months prior, they did not implement remedial actions in a timely manner. Plus, while acknowledging an awareness of consumers smoking in their rooms, the organisation did not implement monitoring/preventative actions to ensure safety. In addition, I am cognisant the provider’s previous commitment to attain compliance was not successfully implemented resulting in a substantial increase in numbers of consumer’s smoking within the building environment. I find requirement 5(3)(b) is non-compliant.

Requirement 5(3)(c) - The service did not demonstrate effective systems/processes to ensure furniture, fittings and equipment are safe, clean, well maintained, and suitable for consumer use. The assessment team observed furniture/furnishings to be unclean and not well-maintained. Examples include minimal furniture in the secure environment, plus furniture to be worn/torn/containing scratches and dirt, chairs appear faded/worn, stained/unclean, providing little support due to inability for adjustment to meet consumers’ needs. Consumers were observed to experience difficulty getting out of chairs with no ability for height adjustment. Overbed table legs contained rust with table-tops containing chipped/exposed particle board, inability to maintain a level position (posing a risk), dining table legs contained rust, and chairs contained dirt. Unclean, torn, rusty furniture presents as a potential infection control and skin integrity risk. Management advised application for government funding to complete major refurbishment projects, including kitchen upgrade, extension to the main dining room and painting throughout the service and planned future funding applications for furniture replacement. In their response, the provider supplied architectural drawings of planned improvements relating to a Capital Grant submission, and noted consultation with consumers regarding planned furniture purchases, however, did not advise either date of Capital Grant submission or purchase dates. In consideration of compliance, while acknowledging responsive actions, the provider did not demonstrate an effective ongoing system to ensure furniture, fittings, and equipment are safe, clean, well maintained, and suitable for consumer use. I find requirement 5(3)(c) is non-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 are encouraged and supported to provide feedback and make complaints and internal and external avenues exist. Internal processes include verbal communication with Management and staff, via feedback forms, secure mailbox situated at various places within the service to enable anonymity, plus consumer meetings. Consumers and representatives consider satisfaction in informing Management and staff of concerns/feedback, noting they feel listened to. Staff demonstrate knowledge of complaints processes and how to assist consumers. Information is available regarding external avenues for raising complaints and accessing advocacy and language services. Consumers and representatives note a preference to raise concerns directly with Management and/or staff. Management explained the process to assist consumers access advocacy/indigenous services and Older Persons Advocacy Network (OPAN). Management explained representatives of consumers living with a cognitive impairment are encouraged to advocate on their behalf, advising NDIS workers advocate for consumers they support. The CEO explained processes to ensure acknowledgement, consultation, and response to those making a complaint and external bodies such as NDIS and The Commission. Staff explain application of open disclosure practices. Consumers consider they had no need to make formal complaints as they are satisfied the service addresses concerns, acknowledging when issues occur and provide an apology. Documents demonstrate management of feedback/complaints in accordance with protocols including use of open disclosure. The service demonstrates feedback/complaints are reviewed to improve quality of care and services. A process ensures monitoring of complaints/feedback received and transfer to relevant meetings. Limited details/actions documented in the PCI has been considered in requirement 8(3)(c).

# 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 demonstrates a planned workforce to enable delivery/management of safe and effective quality care and services, plus sufficient staff with a range of skills rostered across most shifts. Staff from external agencies fill the roster when required. Most consumers and representatives consider consumer needs are met in a timely manner, however 2 consumers raised general issues relating to staff. Most interviewed staff advised they can complete required work. Registered nurses are supported by a care manager and clinical lead and documents reflect 24-hour RN coverage, 7 days a week plus recent addition of a care staff member during night shift. The CEO advised a restructure of staff reporting lines/duties occurred in 2024 to streamline and manage care delivery. Consumers and representatives consider staff interactions to be kind, caring and respectful and the assessment team observed staff respectful of consumer’s identity culture and diversity. Staff demonstrate knowledge of consumers’ cultural needs and support this by providing services in line with their wishes. Consumers and representatives’ express satisfaction staff are trained and competent to deliver care. Position descriptions detail responsibilities and required qualifications/skills and a process ensures the workforce has necessary qualifications/registrations to effectively perform roles. A staff orientation/induction program exists, and a nurse educator employed to provide staff training on site. Staff are required to complete competency assessments relating to medication management, infection control, and manual handling and a process monitors completion. Refer to requirement 8(3)(c) regarding oversight of training.

The service has processes for recruitment, training, and orientation. An electronic training program supports required training as well as selected topics in response to consumer needs, clinical data, and legislative changes, plus a computer literacy module. Management acknowledge evidence of staff training is not documented. The CEO advised restructure of reporting lines occurred to ensure a streamlined, consistent approach to performance review. A system to monitor/review staff performance has recently been implemented post review of policies/procedures, however not all performance appraisals have been completed. The service demonstrated actions in relation to underperformance.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management. 2. continuous improvement. 3. financial governance. 4. workforce governance, including the assignment of clear responsibilities and accountabilities. 5. regulatory compliance. 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers. 2. identifying and responding to abuse and neglect of consumers. 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship. 2. minimising the use of restraint. 3. open disclosure. | Not Compliant |

Findings

Requirement 8(3)(c) - The organisation did not demonstrate effective organisational governance management systems relating to information management, continuous improvement, financial governance, and regulatory compliance, nor monitoring processes to ensure effectiveness and/or identify deficiencies/gaps in processes.

Information management systems include an electronic care planning system and feedback system. A range of meeting forums, reports and other information reported from service level to the executive team and escalated to the board is not consistently occurring. Detailed service information is not being reported at board level to ensure receipt of current/accurate data to enable effective governance/decision making.

Clinical management meet to discuss clinical issues resulting in a report to the governing body via the executive manager. However, clinical governance meetings to do occur and board reports do not consistently contain evidence of discussion nor analysis/outcomes of clinical data to enable Board informed decisions. While national quality indicator program (NQIP) data and SIRS reports are tabled, the organisation cannot demonstrate review/analysis/responsive action occurs. The CEO advised reintroduction of a detailed board report and implementation of an auditing system as an overarching quality system does not exist. They advised engagement of an executive manager of culture, capabilities, and innovations to implementation a quality management system and recommencement of clinical governance meetings. There is no overarching human resource (HR) information management system to assist with oversight of attendance at education. The CEO advised identifying a need for a new HR system sourced via funding from the National Indigenous Australians Agency.

A service-related PCI exists; however, no overarching organisational plan is evident. Via a review of the service PCI the assessment team note limited entries and many outdated. Some evidence of continuous improvements initiated by consumers resulted in installation of air conditioners, however improvement actions referred to by Management relating to cleaning, refurbishment, HR system, clinical governance or risk of consumers smoking in their rooms is not documented. Lack of incident reporting results in inability to analyse/trend incidents to inform quality improvement. A lack of capital and operational budget at service level due to insufficient budget allocation and lack of strategic financial oversight resulted in fragmented spending. The CEO advised and documents detailed recent commencement of changes including recruiting consultants to complete a financial/strategic review to advise/educate the board and executive staff, plus resourcing grant availability as a First Nations service.

A baseline workforce framework monitors staffing numbers, aimed to ensure sufficiently skilled/qualified staff and recent restructure of senior staff occurred, plus updated induction programs and a new protocol for staff absences and performance management.

The organisation did not demonstrate compliance with legislative requirements under SIRS or fire safety regulations. While SIRS incidents are tabled at board meetings, demonstration of discussion/analysis to determine actions to prevent reoccurrence is not evident. In addition, the assessment team note 2 incidents which had not been considered under SIRS reporting requirements. The CEO acknowledged lack of SIRS reporting for both incidents, advising provision of additional staff training to occur. An overarching process to ensure compliance with fire safety regulations does not exist. Demonstration of an effective system to ensure consumers who choose to smoke do so within a designated smoking area is not evident, as such systems to ensure all consumers safety does not exist. Management and staff advised awareness of 15 consumers who smoke in their rooms. The assessment team raised evidence of an increase in the number of consumers smoking in rooms, without evidence of effective risk management strategies, including one consumer smoking while using oxygen resulting in significant concerns for their and other consumers safety due to smoking risks not effectively managed (refer requirements 3(3)(b) and 5(3)(b). In response, Management provided consumers with a letter of intent to immediately cease smoking in rooms/inside buildings and the CEO met with consumers informing of the designated smoking area.

An organisational feedback/complaints policy guides processes and feedback/complaints are reviewed/used to improve some care and services; however, the CEO advised a planned organisational restructure/process to ensure complaints/feedback are consistently addressed. In their response, the provider advised of implementing a new Clinical governance framework, Board reporting templates, trending/analysis process and risk management policy including accepted risk appetite. In addition, development of a monthly budget to demonstrate new strategic spending structure and recorded meeting outcomes, plus implementation of a Board Management Framework detailing required reports, trending/analysis, clinical data, and regularity of meeting forums for Board discussion/review/action. In consideration of compliance, while acknowledging the provider’s actions and recent self-identification of required improvements, remedial actions were not implemented/completed. Effective organisation wide governance systems relating to all aspects of this requirement were not demonstrated. I find requirement 8(3)(c) is non-compliant.

Requirement 8(3)(d) – An organisational risk management framework/system defines risk management, oversight, leadership, and CEO advised awareness of high impact/prevalence risks citing noncompliance to aged care/NDIS standards, workforce/financial risk, and consumer injury/safety (in relation to smoking). However, demonstration of an effective system to management these risks is not evident. In their response, the provider advised of developing a risk register to record/monitor individualised risk, plus implementation of a Board Management Framework detailing required reports, trending/analysis, clinical data, clinical governance report and regularity of meeting forums for Board discussion/review/action and development of policy/procedural guidelines. In consideration of compliance, while acknowledging the provider’s actions and recent self-identification improvements were required, remedial actions were not implemented/completed. Effective organisation wide risk management/governance systems are not evident. I find requirement 8(3)(d) is non-compliant.

Requirement 8(3)(e) – An organisational clinical governance framework enabling effective governance is not demonstrated. A process to ensure the Board is presented with accurate and timely data is not evident and clinical governance meetings do not occur. Policy/procedure guidance do not exist. Board meeting documents do not evidence discussion relating to minimisation of restrictive practice, antimicrobial stewardship nor open disclosure. The CEO acknowledged lack of an effective system to ensure the board received relevant data and advised Board agreement to ensure independent representation. In their response, the provider advised of development of clinical governance framework to include restrictive practices, antimicrobial stewardship, and open disclosure, plus formalise reports containing clinical data analysis for provision to the Board. While acknowledging the provider’s responsive actions an effective clinical governance framework is not evident in relation to all aspects of this required. I find requirement 8(3)(e) is non-compliant.

The remaining requirements 8(3)(a) and (b) are compliant. Organisational processes exist to support consumer and representative involvement in development, delivery of care and services. The CEO and executive team gave examples of differing methods of incorporating consumer feedback/suggestions relating to changes. Consumers meetings result in a representative providing feedback at meetings with facility manager and Board and documents evidence consideration of consumer feedback. Board members visit to engage with consumers and the CEO advised the organisation is proposing development of a consumer advisory body.

The CEO gave examples of promoting culturally safe care/service, inclusive and mindful of consumer/community expectations. Organisational board members possess a variety of skills and cultural expertise. Governance accountability/responsibility is discussed at meetings and respect and quality person-centred care is an organisational requirement. The CEO advised engagement of a legal specialist to review constitutional requirements relating to independent board members, plus implementation of management/reporting restructure. Board members have received clinical governance training, and executive management participated in leadership and financial training, plus an executive manager in culture/capabilities/innovations appointed to promote/drive change and innovation. The assessment team notes lack of an effective system to ensure data is reported to the board and previously committed changes/oversight not implemented in a timely manner (refer to requirements 3(3)(b), and 8(3)(c) and 8(3)(e). In their response, the provider advised of implementing a new Clinical governance framework, Board reporting templates, trending/analysis process and risk management policy including accepted risk appetite.

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)