Performance

Report

**1800 951 822**

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| Name of service: | Bupa Templestowe |
| Service address: | 222-228 Serpells Road TEMPLESTOWE VIC 3106 |
| Commission ID: | 3974 |
| Approved provider: | Bupa Aged Care Australia Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 12 December 2022 to 15 December 2022 |
| Performance report date: | 3 February 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 Bupa Templestowe (**the service**) has been prepared by S Byers delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 10 January 2023
* other relevant matters taken into account in developing this performance report include:
  + the service was issued a Notice of Decision to Impose Sanctions and Notice of Requirement to Agree to Certain Matters in March 2022 following a finding of non-compliance with seven of the eight Quality Standards in 21 requirements. The service did not rectify the non-compliance in Requirements 2(3)(e), 3(3)(b) and 7(3)(c) and the non-compliance is ongoing.
  + the service was issued a Non-Compliance Notice in October 2021 following a finding of non-compliance with the Quality Standards in 2(3)(e), 3(3)(b), 7(3)(c) and 8(3)(d). The service was found to have rectified the non-compliance in 8(3)(d) in February 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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) – the approved provider ensures care and services for each consumer are reviewed both through the service’s routine regular review process and when consumer circumstances change, following incidents and following the consumer’s return from hospital.
* Requirement 3(3)(b) – the approved provider ensures effective management of high impact or high prevalence risks including accurate documentation and charting in line with medical directives, staff are aware of each consumer with high impact or high prevalence risks and how to manage the risk for the individual consumer this includes management of risks in the areas of fluid balance management and oedema management.
* Requirement 7(3)(c) – the approved provider ensures the workforce is competent and have the knowledge to effectively perform their roles including in the assessment and review of consumer care, accurately completing documentation and charting and providing care and services in line with consumer care needs.

# 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)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The service was found Non-compliant in Standard 1 in relation to Requirements 1(3)(a) and 1(3)(f) following a site audit in March 2022 where it was unable to demonstrate:

* Each consumer is treated with dignity and respect in relation to personal care including hygiene and continence care.
* Each consumer’s privacy is respected.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers were satisfied that staff provided care that is respectful and considerate of their preferences relating to their identity, culture and diversity. Consumers and representatives provided positive feedback in relation to personal hygiene assistance and continence care. Consumers were observed to be well dressed, clean and engaged in activities in the common areas throughout the assessment contact. Staff were observed treating consumers with dignity and respect and when interviewed, demonstrated an understanding of the consumers individual cultural preferences. Care planning documents detailed personalised information relating to the consumers choices and preferences and outlined what was important to them. The service has in place policies and procedures covering diversity, dignity and culturally appropriate care. Staff have completed education in relation to culture and dignity.

Consumers expressed satisfaction that their privacy is respected. All consumers confirmed that staff knock and wait for consent prior to entering their bedrooms. Staff described how the consumer’s personal information is kept confidential. For example, information is not discussed in common areas, consumer files are secured and all computers and programs are password protected. Staff confirmed participating in discussions about consumer privacy in staff meetings. Staff and consumer feedback was supported by the Assessment Team’s observations of staff practice and review of documentation during the assessment contact.

Based on the available evidence, summarised above, I find Requirements 1(3)(a) and 1(3)(f) 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

The service was found Non-compliant in Standard 2 in relation to Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) following a site audit in March 2022 where it was unable to demonstrate:

* Assessment and planning considered the risks to the consumer’s health and well-being associated with restrictive practices including mechanical restraint and seclusion.
* Advance care directives for each consumer were transferred to an end of life care plan containing personalised goals and preferences.
* Ongoing partnerships with the consumer or their representatives in assessment and planning; and that assessment and planning included other organisations involved in the care of the consumer.
* Effective or timely communication regarding outcomes of assessment and planning and ready access to care plans.
* Care and services are reviewed following a change to the consumers’ condition, care needs or following incidents.

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirement 2(3)(e) is Non-compliant:

While the service demonstrated it had implemented improvements to address the previous deficits in relation to reviewing consumer care following incidents, the Assessment Team found ongoing deficits in the review of consumer care following changes in condition or circumstance. In relation to a named consumer in the assessment team report, the service did not demonstrate effective or timely review following hospital presentation which resulted in changes to the consumers care needs. Upon the consumer’s return from hospital the service did not review or update the consumer’s relevant assessments and care plans to include vital interventions to inform staff of the new care needs of the consumer. The consumer’s representative was dissatisfied with communication from staff and their lack of knowledge about the interventions recommended by the In-reach nurse. Staff interviewed by the Assessment Team were not aware of the changes to the consumer’s care needs.

While the scheduled training calendar and staff training records reflected education had been provided in relation to assessment and care planning including the review and evaluation of care, staff did not demonstrate application of the learnings in practice. Staff feedback was mixed in relation to the responsibility of reviewing care plans, with some clinical staff stating they are not responsible for reviewing care plans.

The approved provider submitted a written response with clarifying information and documentation including a plan for continuous improvement and training plan. Actions include assessment and care planning education for clinical staff, spot checks of consumer care plans by clinical management and ongoing consultation with the consumers representative.

While I acknowledge that in response to feedback provided by the Assessment Team the consumer’s care plans were updated during the assessment contact, I do not consider the review and update of documentation was completed in a timely manner to ensure the delivery of safe and quality care.

I have reviewed all of the information provided. While I note the approved provider has taken some action in response to the Assessment Team’s findings both during and after the assessment contact, these actions have not been fully implemented, evaluated or embedded. While I am satisfied the approved provider has implemented improvements to demonstrate care and services are reviewed regularly as part of monthly reviews and when incidents occur, I am not satisfied the approved provider has implemented and embedded effective improvements in relation to review of consumer care when their circumstances change or upon return from hospital. I find Requirement 2(3)(e) is Non-compliant.

I am satisfied that Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) are Compliant:

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit in relation to 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d).

Consumers and representatives confirmed they are aware of the risks to the consumer and were satisfied with the consultation process. Consumer care files reflected consultation with consumers and representatives. Risk assessments, authorisations and informed consent were documented in care files for consumers subject to restrictive practices. The service has updated its restrictive practice register and implemented a 3 monthly review of restrictive practices including consultation. The service demonstrated it has policies and work instructions in place to guide staff on the assessment and care planning process, and the assessment and procedure for restrictive practices.

Consumers and representatives were satisfied the service identifies and addresses the consumers end of life wishes. Representatives confirmed feeling included and well informed by the service, general practitioner and palliative care provider. The Assessment Team observed advanced care directive documentation was available in hard copy and uploaded to the electronic care system along with end of life care plans. End of life care plans were personalised and reflected the consumer’s current needs, goals and preferences. Clinical staff described how they consult with consumers regarding their end of life care preferences and demonstrated how they access consumers advanced care directives.

Consumers and representatives confirmed they have been given the opportunity to be involved in assessment and care planning. Care planning documents demonstrated ongoing partnership between consumers and representatives with documented participation in care conferences and the involvement of a range of external providers and other health services such as general practitioners, and allied health specialists. Management and staff described how consumers, representatives and other providers of care collaborate in assessment and planning to ensure delivery of safe, effective and personalised care. Staff demonstrated understanding of the process to refer consumers to allied health and specialist services. Clinical staff had completed training in the care planning assessment process and consultation.

All sampled consumers and representatives confirmed that they are offered the consumers’ care plan and expressed satisfaction with the consultation process. Care files reflected outcomes from assessments were documented using easy to understand language. The service’s electronic care system prompts staff to actively inform consumers and representatives that a copy of the care and services plan is available and can be requested. Staff demonstrated how they access care plans in the electronic care system.

# 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. | Non-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)(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 |

Findings

The service was found Non-compliant in Standard 3 in relation to Requirements 3(3)(a), 3(3)(b), 3(3)(c) and 3(3)(e) following a site audit in March 2022 where it was unable to demonstrate:

* Each consumer received clinical care that was best practice and tailored to their needs in relation to the management of wounds, pain and restrictive practices.
* Effective management of high impact or high prevalence risks in relation to falls, weight loss, responsive behaviours and fluid balance management.
* End of life wishes of consumers are recognised and addressed or that interventions to ensure a consumer’s comfort were maximised.
* Effective and consistent care planning documentation and communication with representatives.

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirement 3(3)(b) is Non-compliant:

While the service demonstrated it has implemented improvements to demonstrate effective management of falls, weight loss and responsive behaviours, the Assessment Team found ongoing deficits in the management of high impact and high prevalence risks including fluid balance management and oedema management.

The Assessment Team’s evidence included two named consumers with medical directives in place to maintain a strict fluid intake restriction and complete fluid balance charting. Care files for both consumers demonstrated incomplete charting and inconsistencies in documenting intake and output of fluids. One of the named consumers was also named in the previous site audit report for the March 2022 site audit and the Assessment Team identified the deficits in fluid balance management had not been effectively addressed and remained ongoing during the current assessment contact. The same named consumer had a medical directive in place to wear compression stockings to manage oedema. Throughout the assessment contact the consumer was not observed wearing compression stockings in line with the medical directive and staff were unaware of the directive. The Assessment Team also identified deficits in food and fluid intake charting for a consumer with identified weight loss. Several staff confirmed they are required to complete charting; however, they could not describe the fluid monitoring requirements for the named consumers. Mixed feedback was received from clinical staff on their understanding of the services work instructions for high impact and high prevalence risks including nutrition and hydration intake.

I acknowledge that during the assessment contact a dignity of risk form was completed by management in consultation with the named consumer to reflect their choice to not follow the medical directive to wear compression stockings.

The approved provider submitted a written response with clarifying information and documentation including a plan for continuous improvement and training plan. Actions include communication issued to staff to complete charting and evaluate fluid intake, reviewing charting, re-establishment of internal handover processes and education in documentation and charting.

I have reviewed all of the information provided. While I note the approved provider has taken some action in response to the Assessment Team’s findings both during and after the assessment contact, these actions have not been fully implemented, evaluated or embedded. While I am satisfied the approved provider has implemented improvements to demonstrate effective management of risks including falls, weight loss and responsive behaviours, I am not satisfied the approved provider has implemented and embedded effective improvements in relation to fluid balance management and oedema management. I find Requirement 3(3)(b) is Non-compliant.

I am satisfied that Requirements 3(3)(a), 3(3)(c) and 3(3)(e) are Compliant:

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit in relation to 3(3)(a), 3(3)(c) and 3(3)(e).

Consumers and representatives provided positive feedback with regard to the improvements made by the service in relation to the delivery of clinical care in the areas of pain management, skin integrity and wound management. File reviews demonstrated consumers receive appropriate pressure injury management with pressure relieving equipment and interventions in place to reduce further injury, pain medication is given as required with effectiveness recorded and consistent monitoring of restrictive practices with consultation and consent processes are followed. Wound management plans and charting demonstrated pain management is considered and provided to consumers prior to the commencement of wound care. For consumers prescribed psychotropic medications, non-pharmacological interventions were trialled and the medication was administered as a last resort in line with behaviour support plan interventions. Referrals to general practitioners and health providers were actioned in a timely manner where appropriate. Staff demonstrated knowledge and understanding of consumer’s individual care needs.

Representatives said they felt supported, informed and encouraged to be included in the consumers end of life pathway. Most care files had advanced care directives uploaded to the electronic care system, with hard copies also available. Care documentation demonstrated care is provided in accordance with consumer’s wishes, with comfort maximised and dignity preserved. Staff have completed training in end of life care and advanced care planning. The service has in place consultation and referral processes to enhance consumer comfort, provide sensitive and dignified care inclusive of the consumer, their representatives, general practitioner and/or external palliative support provider. Staff demonstrated understanding of referral processes.

Most representatives interviewed said they are satisfied with the improvements made to the regular care review and communication when incidents occur. Care files demonstrated regular consultation between staff, consumers or representatives. Handover sheets detailed the current care needs and charting requirements of each consumer. The Assessment Team observed handover between shifts, the daily clinical meeting and the ‘on floor’ presence of the clinical management team. Allied health specialists confirmed receiving referrals and have access to the electronic care system to review consumer notes. In response to feedback received that care staff are not included in the morning handover between the night duty nurse and the day shift nurses, management responded by extending care staff shifts by 15 minutes to allow for all staff to be included in the handover, especially in the memory support unit where the agency or casual staff rely on the consumer knowledge of the care staff.

# 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 |

Findings

The service was found Non-compliant in Standard 4 in relation to Requirements 4(3)(a) and 4(3)(b) following a site audit in March 2022 where it was unable to demonstrate:

* The lifestyle program included services and supports for daily living that met the individual needs and preferences of each consumer, particularly those consumers residing in the Memory Support Unit (MSU).
* Services and supports for daily living, particularly for those consumers required to isolate due to COVID-19 restrictions or personal choice promoted emotional, spiritual and psychological well-being.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives provided positive feedback in relation to the improved lifestyle program, in particular consumers were satisfied with the increased bus outing into the community. Consumers in the MSU were observed to have activity tubs that were tailored to reflect their personal interests. The Assessment Team observed consumers in the MSU participating with support from staff in two musical performances during the assessment contact. Consumer lifestyle documentation detailed individual consumers personalised needs and preferences in relation to daily supports. Staff knowledge aligned with information in the consumer’s care plans. The service has recruited additional lifestyle staff to coordinate the lifestyle program with lifestyle staff rostered seven days a week. All lifestyle staff have completed relevant training. While recruitment for a lifestyle coordinator is ongoing, in the interim the regional lifestyle coordinator is supporting the service.

Consumers and representatives were satisfied the consumers’ emotional, spiritual and psychological well-being is supported. Religious and cultural visitors have been reinstated with associated activities included in the lifestyle program. The service has engaged an external psychologist to be available to consumers and representatives on request. For consumers required to isolate due to COVID-19 restrictions or personal choice, the service has implemented a support program including activity packs and one on one support from staff to promote emotional, spiritual and psychological well-being. Staff demonstrated knowledge of individual consumer needs and preferences and provided specific examples where they had utilised the activity packs and provided one on one support. This aligned with Assessment Team observations of consumer’s receiving hand massages and one on one support throughout the assessment contact.

Based on the available evidence, summarised above, I find Requirements 4(3)(a) and 4(3)(b) are Compliant.

# Standard 6

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

Findings

The service was found Non-compliant in Standard 6 in relation to Requirement 6(3)(c) following a site audit in March 2022 where it was unable to demonstrate:

* Appropriate action was taken in response to complaints and incidents, and the use of open disclosure.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives provided positive feedback in relation to the resolution of complaints and communication about incidents. Complaints documentation demonstrated meetings with the complainant are initiated in a timely manner, open disclosure is practiced and supporting documentation including emails demonstrated the service implements appropriate actions to address the concerns raised. Follow-up consultation with the complainant is documented to ensure satisfactory resolution. Incident reports demonstrated that communication with the consumer and their representative occurred promptly after an incident and that actions to minimise re-occurrence are documented and communicated to relevant stakeholders. Clinical staff and management described open disclosure and how it relates to their role including maintaining communication with consumers and representatives. Education records confirmed staff attended training in communication requirements and open disclosure principles.

Based on the available evidence, summarised above, I find Requirements 6(3)(c) is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was found Non-compliant in Standard 7 in relation to Requirements 7(3)(a), 7(3)(c), 7(3)(d) following a site audit in March 2022 where it was unable to demonstrate:

* Sufficient staffing levels and mix of staff skill are planned and deployed to deliver and manage safe and quality care and services.
* The workforce was competent and had sufficient knowledge to effectively perform their roles in relation to incident management, completion of clinical documentation, pain management, psychotropic medication use, restrictive practices and charting, evaluation and implementation of care interventions.
* The workforce had completed mandatory training and were trained and equipped to deliver outcomes under these Standards.

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirement 7(3)(c) is Non-compliant:

Through documentation review and staff interviews the Assessment Team identified deficits in staff understanding of roles, responsibilities and documentation requirements in relation to the provision of clinical care to consumers. Staff did not demonstrate competence and knowledge of the improvements implemented by the service in relation to care reviews following a change in condition or return from hospital and management of risks associated with fluid balance restrictions management and oedema management as demonstrated in Standard 2 Requirement 2(3)(e) and Standard 3 Requirement 3(3)(b) where both requirements have been found Non-compliant. While the service demonstrated that comprehensive training had been delivered to staff to address the deficits identified in the March 2022 site audit, staff could not demonstrate application of the learnings in practice.

The approved provider submitted a written response with clarifying information and documentation including a plan for continuous improvement and training plan. Actions include further training in assessment and care planning, catheter management and fluid monitoring charting.

I have reviewed all of the information provided. While I note the approved provider has taken some action in response to the Assessment Team’s findings both during and after the assessment contact, these actions have not been fully implemented, evaluated or embedded. I am not satisfied the approved provider has implemented and embedded effective improvements to demonstrate the workforce is competent and has knowledge to perform their roles under these Standards. I find Requirement 7(3)(c) is Non-compliant.

I am satisfied that Requirements 7(3)(a) and 7(3)(d) are Compliant:

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit in relation to 7(3)(a) and 7(3)(d).

Consumer and representative feedback was primarily positive in relation to staffing levels and call bell response times. Staff confirmed they have sufficient time to complete their work and attend to consumers who require assistance. Management described the strategies in place to improve staffing including recruitment of additional lifestyle staff, general manager and quality education manager. The service has commenced block booking of agency staff to fill known shortfalls and reviewed the master roster. Call bell response times are monitored daily by management. Roster documentation demonstrated sufficient staffing levels and skill mix with registered nurses rostered 24 hours a day with enrolled nurse support. In addition to rostered clinical staff, management advised the general manager, clinical manager and quality education manager who are all registered nurses are also available to assist Monday to Friday. Roster documentation demonstrated most shifts are filled through the use of part-time and casual staff. While the Assessment Team identified some unfilled care staff shifts, a review of associated call bell and incident reports demonstrated no incidents or delays in call bells occurred during these periods. Call bell reports demonstrated call bells are responded to in a timely manner.

Staff confirmed they are provided orientation, buddy shifts and training on commencement at the service. Staff were satisfied with the training provided. The completion of staff mandatory training is monitored with training recorded in the electronic care system. Management described how they review staff and consumer feedback, performance reviews and incident data to identify staff knowledge deficits and schedule relevant training to address the deficits. Since the site audit, staff have completed training and education in culture and dignity, care planning and assessment, referrals, SIRS and incident reporting. Clinical education has been delivered in relation to restrictive practices, skin integrity, falls, responsive behaviours, weight, medication and fluid balance. Training records demonstrated that 98% of staff have completed annual mandatory training. The service has recruited additional staff to fill roster shortfalls including in lifestyle. Overall, staff demonstrated they have been trained, equipped and supported to deliver outcomes under the Quality Standards. While deficits were identified in staff practice under Requirements 2(3)(e) and 3(3)(b), these deficits have been considered under Requirement 7(3)(c) in relation to workforce competency and knowledge.

# 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. | 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. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was found Non-compliant in Standard 8 in relation to Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e) following a site audit in March 2022 where it was unable to demonstrate:

* Consumers are engaged in the development, delivery and evaluation of care and services.
* Effective organisation wide governance systems in relation to continuous improvement, workforce governance and feedback and complaints.
* Effective risk management systems and practices to manage high impact and high prevalence risks.
* An effective clinical governance framework that supported the management and minimisation of restrictive practices.

At the December 2022 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

Consumers and representatives confirmed being engaged in the development, delivery and evaluation of care and services. Consumers and representatives provided positive feedback about the improvements made to communication and care planning processes. Management described how they encourage consumer feedback on care delivery through the ‘resident and representative’ meetings and through individual care conferences. Case conference records, incident and SIRS reports demonstrated consultation with consumers and representatives. Consumer and representative meeting minutes demonstrated consumers are encouraged to engage in the development of care plans, provide feedback on care and review care provision. Representatives confirmed attending the monthly meetings.

The organisation demonstrated it has effective organisation wide governance systems in relation to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints. The organisation has implemented improvements in relation to continuous improvement, feedback and complaints and workforce governance systems. The service has reinstated the use of their plan for continuous improvement which details opportunities for improvement are identified through consumer and representative feedback, changes in legislation and the results of internal and external audits. Management demonstrated through the review of SIRS incidents that they are aware of reporting timeframes for SIRS incidents, practice open disclosure and monitor staff qualifications and performance. Complaint registers viewed demonstrate that feedback is responded to in a timely manner, actions documented and follow-ups scheduled with the complainant to ensure agreed outcomes are met. Trending of feedback and complaints is completed and documented appropriately. Management and staff demonstrated understanding of the policies and processes that supported each of the governance systems. The service has demonstrated improvement in workforce planning, recruitment, training and support as demonstrated under Standard 7, Requirements 7(3)(a) and 7(3)(d) where both requirements have been found Compliant. While Requirement 7(3)(c) has been found Non-compliant, in my view the deficits in relation to staff capability and knowledge sit at service level and the practical application of care and do not demonstrate deficits in organisational governance. On balance I am satisfied, the organisation has demonstrated effective workforce governance systems.

The organisation demonstrated it has effective risk management systems in place supported by policies and procedures documented to manage risk, abuse and neglect of consumers, supporting consumers to live the best life they can and incident management. Staff and management described their roles in managing and identifying risks and provided specific examples of how risks to consumers are identified and managed. While the service demonstrated effective management of the high impact and high prevalent risks of consumers in relation to falls, weight loss, restrictive practices and responsive behaviours, the Assessment Team identified ongoing deficits in fluid balance management which I have considered under Standard 3, Requirement 3(3)(b). The service has an incident management system in place and staff demonstrated understanding of incident reporting processes and responsibilities. Clinical management discussed how they review incidents, ensuring appropriate actions are taken in a timely manner. Incidents and SIRS reports demonstrated management of suspected abuse and neglect are effectively managed. On balance, I am satisfied the organisation has demonstrated effective risk management systems and practices.

The organisation demonstrated it has a documented clinical governance framework which includes antimicrobial stewardship, minimising the use of restraint and open disclosure policies and procedures. Management and staff demonstrated understanding and practical application of the policies and procedures. Documentation demonstrated the service is monitoring psychotropic medications, identifying and monitoring restrictive practices, engaging with consumers and representatives and minimising restraint as demonstrated under Standard 2, Requirements 2(3)(a) and Standard 3(3)(a) where both requirements have been found Compliant. Training records confirmed staff had completed training in restrictive practices. Incident reports demonstrated open disclosure principles are practiced.

Based on the available evidence, summarised above, I find Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e) are Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)