Performance

Report

**1800 951 822**

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| Name of service: | Burrowa House |
| Service address: | 79 Ford Street BOOROWA NSW 2586 |
| Commission ID: | 0260 |
| Approved provider: | Boorowa Hostel Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 March 2023 to 22 March 2023 |
| Performance report date: | 21 April 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 Burrowa House (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This Performance Report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

**Material relied on**

The following information has been considered in preparing the Performance Report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment conducted 21 March to 22 March 2023, 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 12 April 2023
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Notice of Decision to Impose Sanctions and Notice of Requirements to Agree to Certain Matters dated 1 September 2022; Non-Compliance Notice issued to you on 25 August 2022 in relation to Site Audit conducted 31 May to 2 June 2022; Assessment Contact Report for the Assessment Contact conducted 24 August 2022; Performance Report dated 4 August 2022 for the Site Audit conducted 31 May to 2 June 2022; Site Audit Report for the Site Audit conducted 31 May to 2 June 2022.

**Assessment summary**

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

**Areas for improvement**

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

* **Requirement 2(3)(a)**  The approved provider must demonstrate that assessments are undertaken to identify consumers’ risks. Risks and mitigation strategies must be recorded in consumers care plans.
* **Requirement 2(3)(b)**  The approved provider must demonstrate that consumers’ care planning documentation reflects their current needs, goals and preferences. Information regarding management strategies for consumers care must be documented.
* **Requirement 2(3)(e)** The approved provider must demonstrate that when incidents occur, they are documented and investigated with regular review of interventions to demonstrate that consumers care needs, goals and preferences are current and known to all staff.
* **Requirement 3(3)(a)**  The approved provider must demonstrate that consumers receive safe and effective personal care and clinical care and that it is individually tailored and regularly monitored and documented for the care of the consumer.
* **Requirement 3(3)(b)** The approved provider must demonstrate that an effective risk management and incident management system is in place to address effective management of high prevalence and high impact risks to consumer and that incident management includes effective review and investigation.
* **Requirement 3(3)(d)**  The approved provider must demonstrate that consumers are monitored effectively to identify deterioration and that deterioration is responded to in a timely manner. Staff must understand the importance of accurately classifying wounds and responding to them appropriately.
* **Requirement 6(3)(d)** The approved provider must demonstrate that there is an effective complaints process and that all feedback and complaints are documented, reviewed and actioned to inform continuous improvement.
* **Requirement 7(3)(c)**  The approved provider must ensure that staff can demonstrate practical competence and knowledge associated to effectively perform their roles.
* **Requirement 7(3)(d)**  The approved provider must demonstrate that staff undertake training relevant to the Quality Standards and they are conversant in these areas. The provider must also demonstrate that staff appraisals are conducted and that non-compliance with training is followed up.
* **Requirement 8(3)(c)**  The approved provider must demonstrate that there is effective organisation wide governance systems relating to the following areas; information management; to ensure that all consumers information is documented accurately and accessible by staff who need to have access to this and that policies and procedures are accessible to staff, a feedback and complaints register that documents all feedback and complaints for continuous improvement and a continuous improvement plan that addresses gaps identified through self-assessment and commission audits, workforce governance, including the assignment of clear responsibilities and accountabilities including compliance with training and demonstrated competence in roles; regulatory compliance with the Quality Standards is communicated and understood by all staff. It is understood that the Board has an established financial and governance sub-committee to provide a strong oversight of income and expenditure within the organisation.
* **Requirement 8(3)(d)**  The approved provider must demonstrate that there is effective risk management systems and practices, including incident management systems and adequate clinical oversight of high impact, high prevalence risks to consumers living at the service.
* **Requirement 8(3)(e)**  The approved provider must demonstrate that there is an effective clinical governance framework that has oversight of antimicrobial stewardship, minimising the use of restraint and open disclosure and that staff are trained and can demonstrate practical competence with the policies and procedures regarding antimicrobial stewardship, restrictive practices and open disclosure.

**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. | Non-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. | Non-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 Quality Standard is assessed as non-compliant as three of the five specific requirements were found to be non-compliant.

The following requirements 2(3)(a) and 2(3)(e) were found to be non-compliant following the Site Audit conducted on 31 May to 2 June 2022. Requirement 2(3)(b) was found non-compliant following an Assessment Contact in August 2022. The Assessment Team finds these requirements continue to be non-compliant. The service engaged an aged care consultant who continues to support the service on a weekly basis. A number of improvements are planned, some of these have been conducted, however have not been demonstrated as effective at this point. These improvements include a reassessment of all consumers’ clinical care needs and care plans occurred in November/December 2022. The service has highlighted consumers who have been identified as having a high falls risk on the AIN’s (assistants in nursing) handover sheet to communicate their risks with staff. Management said they plan to develop a risk register however this has not been implemented yet. During the assessment contact visit, a document was provided to the Assessment Team which includes consumers’ names and outlines their risks. A ‘resident of the day’ program has been introduced to review each consumer’s clinical and personal care every 2 monthly, including re-assessment, review of their summary care plan and a case conference with the consumer or representatives on their behalf.

However, the Assessment Team identified gaps with information identifying risks to consumers’ health and well-being is not available in their care plans. Assessments are not undertaken to identify consumers’ risks. Summary care plans do not include consumers’ risks and information regarding risks to consumers health is not communicated accurately on handover sheet. Clinical oversight of the ‘resident of the day’ program is not evident.

The Assessment Team interviewed management and the registered nurse who said the program commenced 1 March 2023 and the majority of the 20 consumers had been reviewed and had case conferences, however the resident of the day folder indicated less than half of the consumers have had a case conference, however records of consumers’ case conferences could not be found. Management said the 4 new consumers have not yet had case conferences. Information in consumers’ ‘resident of the day’ documentation regarding risks such as restrictive practice differs from information in their associated care planning documentation.

The Assessment Team identified there were inconsistencies with how wounds were classified, there were no interventions outlined in care plans to mitigate the high risk of pressure injuries. Consumers who are at high risk of falls, were classified incorrectly on the risk assessment and there was no detail of falls risk on the AIN handover sheet. The Assessment Team identified the organisation’s schedule for assessments on entry to the service does not address risks such as pain, nutrition, pressure injury, falls and mobility in a timely manner.

The Assessment Team found sampled consumers’ care planning documentation does not reflect their current needs, goals and preferences. The Assessment Team identified that for a consumer with a high risk of pressure injuries there was no information regarding the pressure injury management except that the consumer has a pressure mattress. This was also found for consumers with diabetes, there were no diabetes management plans outlining goals, needs or preferences, inconsistent monitoring of blood glucose levels were documented.

The Assessment Team interviewed staff who said that they do not have time to ensure all consumers’ care plans are reviewed every 2 months. They said the registered nurses only work on the morning shift and most of their time is spent doing medication rounds and wound dressings. They said they focus on attending to wound dressings however do not have time to fill in the wound evaluations on the wound charts.

Incidents are documented into the electronic documentation system by the care staff or registered nurses if they are present and an alert is set up for the registered nurse to complete the incident report with any investigation or follow up.

The facility manager said they report on incidents to the Board monthly, however the Assessment Team finds the service did not demonstrate a clear system of analysis or review of incidents. Details on the monthly report to the Board did not match details in the incident reports. For example: The February 2023 quality indicators report states there were 3 falls with major injury. One of the falls describes an incident on 18 February 2023 where the consumer was struck by a door when staff were entering the room and the consumer sustained a fall and skin injury. The incident form does not record that the consumer experienced a fall at this time. The Assessment Team also noted that not all incidents are captured on incident reports.

The approved provider responded to the Assessment Team’s report and provided a copy of the Continuous Improvement Plan and other attachments including interim and summary care plans. I have reviewed the documentation; however, it does not satisfy me that there is information to support compliance and I noted that the care plans provided contained inconsistencies for the care of consumers. I have also noted that there are minimal risks identified or evidence of blood glucose monitoring or interventions for consumers with pressure care needs.

I find that the approved provider is non-compliant with requirements 2(3)(a), 2(3)(b) and 2(3)(e).

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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)(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. | Non-compliant |

**Findings**

The Quality Standard is assessed as non-compliant as three of the seven specific requirements were found to be non-compliant.

The following requirements 3(3)(a) and 3(3)(b) were found to be non-compliant following the Site Audit conducted on 31 May to 2 June 2022. Requirements 3(3)(c) and 3(3)(d) were found to be non-compliant following an Assessment Contact in August 2022. The Assessment Team finds requirements 3(3)(a), 3(3)(b) and 3(3)(d) continue to be non-compliant. The service engaged an aged care consultant who continues to support the service on a weekly basis. An action plan has been put in place to address gaps including re-assessment of all domains of each consumer’s personal and clinical care needs, commencing a schedule for review of care plans and introducing case conferencing. The manager said they have recommenced reporting quality indicators to the Board monthly. Additionally, registered nurses are being recruited to cover more shifts and provide more clinical oversight, training has been provided to staff to assist them with their knowledge of identifying the deteriorating consumer.

The Assessment Team interviewed consumers and representatives on their behalf are mostly satisfied with the personal and clinical care provided. They report staff are kind and caring and while they might have to wait some time for assistance, it is at busy times and the staff do the best they can. The Assessment Team reviewed the care of sampled consumers, speaking with consumers and staff about their care and reviewing consumers’ clinical documentation and found some areas for improvement regarding the provision of safe and effective personal and clinical care.

At the entry meeting management reported no consumers at the service had pressure injuries, however this was not accurate. The Assessment Team identified that the wound chart does not include details such as the repair stage, colour, odour, exudate or description of surrounding skin condition. The wound has been attended either second daily or third daily. Each registered nurse has used a different time frame for reviewing the wound. Registered nurses have described the wound as a stage 3 pressure injury or a stage 4 pressure injury depending on who has attended the wound. The wound dressings used are changed depending on which registered nurse has attended the wound. Staff said they have not considered doing a wound swab on the consumer’s wound to identify infection.

The service reported that there are no consumers who are mechanically, isolated or physically restrained. Management said there are a number of consumers who are chemically restrained; however, a review of the psychotropic management and consent forms indicates no consumers are chemically restrained. The manager advised she said there were some because they were on medication that could be used as a chemical restraint. Management and the registered nurse acknowledge they do not have a strong understanding of chemical restraint. The service does not demonstrate systems to identify and appropriately manage chemical restraint.

The Assessment Team identified the psychotropic management and consent forms state ‘informed consent’, however there is no documentation regarding what the signatory is informed of. The form states that the next of kin is required to review every 12 weeks however management said the next of kin only sign when the medication is first prescribed, and the doctor reviews every 12 weeks.

The Assessment Team identified that staff do not have knowledge of antimicrobial stewardship. The service does not follow best practice with the use of antibiotics, with two consumers have been prescribed long term antibiotics for urinary tract infections. The Assessment Team identified that medication given on as required basis is not evaluated for effectiveness. The registered nurse said they attend the morning and lunchtime medication rounds which take a long time (up to 4 hours). They said this leaves very little time for documentation, clinical assessment and reviewing care plans. Management said they are aware of this and have enrolled 4 care staff in a training course to enable them the knowledge to give medications, however they have since found out the course does not have a medication management component to it, so they are looking at finding an appropriate course.

The Assessment Team also noted some gaps in behaviour management, where no strategies or evaluation was recorded.

The Assessment Team found that information provided in the quality indicator reports does not demonstrate effective management of high-prevalence or high impact risk. Information is brief, does not include analysis of data collected or actions taken to minimise risks to consumers.

Management said they plan to develop a risk register however this has not been implemented yet. During the assessment contact visit, a document was provided to the Assessment Team which includes consumers’ names and outlines their risks, however the risks do not correlate with what is documented on the staff handover sheet.

The Assessment Team identified for sampled consumers that the risks associated with their conditions had not been appropriately managed, these included risks for wound management, diabetes management, catheter management, falls risks, skin integrity, behaviour management and personal hygiene.

The Assessment Team identified consumers are not assessed following incidents in a timely manner to identify and address deterioration. Falls Risk Assessments were not conducted in a timely manner following falls and wound charts and blood glucose levels are not monitored. The Assessment Team noted for one consumer their condition had deteriorated since entering the service.

The approved provider responded to the Assessment Team’s report with the Continuous Improvement Plan, however it did not specifically address the gaps identified and in response to antimicrobial stewardship, did not have a completion or review date for follow up. Copies of policy and procedures were also furnished; however, they did not demonstrate that they are being applied to consumers. I am not satisfied that the provider has addressed the gaps with the information provided, as it does not demonstrate that consumers get safe and effective care, high prevalence and high impact risks are identified and managed or that deterioration is effectively managed for consumers.

I find that requirements 3(3)(a), 3(3)(b) and 3(3)(d) are non-compliant.

The Assessment Team found that requirement 3(3)(c) was non-compliant in in August 2022. The Assessment Team identifies work is still in progress to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, however review of a sampled consumer’s file who recently died and discussion with staff and management indicate the consumer was provide with palliative care that met the needs, goals and preferences of the consumer.

The clinical consultant who has been contracted by the service said they have worked with staff to provide training on palliative care. The new facility manager said they have identified staff continue to require additional training to build their confidence. They said consumers at the service have previously had their palliative care needs met at the local hospital and staff had not any experience with death and dying. The facility manager said they have liaised with the local palliative care team to provide further training to staff. Additionally, the service has purchased equipment such as a suction machine to support consumers’ palliative care requirements.

I have found requirement 3(3)(c) to be 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

**Findings**

The requirement 6(3)(c) was found to be non-compliant following the Site Audit in May 2022. During the Assessment Contact in March 2023, the Assessment Team found that the service currently has an active complaints/feedback register, and all consumers interviewed indicated that any concerns they raise about their care and services are dealt with in a timely manner at service level. They said that staff acknowledge when mistakes occur or when things go wrong.

The Assessment Team interviewed consumers and they stated that they are generally satisfied with the care and services delivered to them and indicated they felt confident to raise any concerns directly with management, saying the service manager “has an open-door policy, and gets things done.

Clinical and care staff interviewed explained the service’s complaints and open disclosure processes, although one care staff member was not immediately familiar with the term ‘open disclosure’, or its meaning. Management stated that several consumers recently complained that the temperature of the tea served to them was not hot enough. Management stated that it responded immediately by reviewing the service’s food handling and serving processes to ensure that the issue was resolved in a timely manner.

The service facilitates a monthly ‘residents meeting’, and a review of the meeting minutes confirmed that the service is recording issues raised by consumers in that forum. The service demonstrated that its open disclosure policy is in final draft for ratification by the Board at its next meeting in April 2023.

I have found requirement 6(3)(c) is compliant.

The requirement 6(3)(d) was found to be non-compliant following the Site Audit in May 2022. During the Assessment Contact in March 2023, the Assessment Team found the service is currently unable to demonstrate that it effectively identifies and consistently records all feedback and complaints, that it adequately applies feedback information to its Continuous Improvement Plan, or that it refers that information to the Board to ensure the ongoing practice of good governance at the service.

The Assessment Team interviewed management who said that recent complaints from consumers about their tea not being hot enough when delivered to them by staff, prompted a review of the process to address this complaint. However, the complaints register does not contain a report about this issue, or the subsequent action taken to resolve the matter.

Management stated that it does not currently have a process whereby progress notes and other collected information are regularly reviewed to ensure that incidents, complaints and feedback are consistently captured, registered, and addressed accordingly to improve care and services.

A review of resident meeting minutes for September 2022 to December 2022 contained consumer feedback about needed improvements to laundry and meal delivery services, and management stated that the feedback received at those meetings is utilised by staff to improve service delivery.

A recent Board meeting agenda reviewed did not contain evidence of any incidents, feedback from resident’s meetings or complaints/feedback data for review, and management confirmed that the service does not currently have a process in place whereby complaints and feedback are consistently recorded and analysed to improve the overall care and services delivered to consumers.

The approved provider responded to the Assessment Team’s report with copies of Resident Meeting minutes for February 2023 and March 2023, with the actions noted, however there is no evidence that this has been transferred to the complaints and feedback register or that it was included in the Continuous Improvement Plan.

I find that the approved provider is non-compliant with requirement 6(3)(d).

**Standard 7**

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| Human resources | |  |
| 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. | Non-compliant |

**Findings**

Requirements 7(3)(c) and 7(3)(d) were found to be non-compliant following an Assessment Contact in August 2022. The service has since recruited a new facility manager in January 2023, who is a qualified registered nurse with management experience in acute and community care. The service has also recently recruited a casual enrolled nurse and is actively recruiting for additional registered nurses and care staff.

However, the service was unable to effectively demonstrate that clinical and care staff had the knowledge and skills to support consumers with high impact and high prevalence risks, such as post-falls management, deterioration in condition, wound management, and the provision of personal care. The Assessment Team found that although the service’s training records indicated that staff have completed mandatory training, deficits exist in clinical and care delivery relating to high impact or high prevalence risks, assessments and care planning.

The Assessment Team found that although the service demonstrated a 100% compliance rate for its 2022 mandatory training schedule, examination of its role specific training schedule for January 2023 and February 2023 indicates that staff completion rates for courses are well below 100%, such as ‘Minimising Restrictive Practices’ and ‘High Impact Risk – Medication Safety’ which have respectively, 48% and 64% completion rates. When asked whether follow-up has occurred for those staff members who have not completed the specified training for their roles, management indicated that it has not.

Management discussed, and a document review confirmed, that the organisation has an effective recruitment and selection process, which includes pre-employment checks, clinical status confirmation, and aged care specific qualifications. Newly recruited staff are scheduled ‘buddy’ shifts under the supervision of a suitably qualified and experienced staff member, to ensure they are supported to obtain full competency in their role. However, the Assessment Team observed on several occasions during the Assessment Contact visit that a newly recruited enrolled nurse was being buddied on their first shift by an inexperienced care staff member.

The Assessment Team found that management was not able to provide adequate evidence that staff performance appraisals and non-mandatory training requirements are up to date and regularly monitored by management. It also found that there is insufficient documentary evidence that individual clinical and care staff are receiving adequate and ongoing training in SIRS, dementia care, risk management and restrictive practices.

The Assessment Team interviewed staff and found that staff were not able to explain what measures are taken by management if there is ongoing non-compliance with training requirements, or how potential gaps in knowledge are identified and addressed via additional education and competency training. One staff member interviewed by the Assessment Team did not have a sound knowledge of chemical restraint and psychotropic medication management in an aged care setting and another staff member interviewed was not fully conversant with what constitutes a serious incident and was unable to provide an overview of the SIRS principles and reporting procedures.

A document review of consumers’ clinical files by the Assessment Team identified that clinical staff are not consistently completing evaluations for PRN medication administration and are not consistently completing consumers’ existing pain charts.

Management stated that it has established an audit schedule for 2023 to improve its operational, clinical and education oversight of all staff. However, since the inception of its audit schedule in January 2023, the service has only conducted clinical audits relating to pain management and behavioural management. Management was unable to explain how the results of audits conducted have been communicated to the Board and used to improve care and services. The audit schedule for 2023 indicates that audits for pain management, behavioural management and wound care occur once a year, and that medication administration and documentation audits occur every 6 months. Management was unable to provide evidence that additional systemic oversight of its clinical operations is conducted in the intervening periods.

Management indicated that it plans to follow-up training deficits with individual staff members when their respective appraisals are due, but it confirmed that although it plans to do so, it does not currently have a staff appraisal schedule in place.

The approved provider responded to the Assessment Team’s report with a copy of the February Facility manager’s report which included the number of falls, infection control, medication incidents, recruitment and other general business. A copy of the Monthly Board report was provided for March 2023, however this was noted to have inaccurate information for pressure injuries, discussed pain management audit and behavioural audit, however there was no detail as to the analysis of this report. The provider also advised that they will be undertaking staff appraisals, however it was unrealistic to expect that should occur within two months of the manager commencing.

I have reviewed the information provided and acknowledge that there will be processes implemented, however it has not been practically demonstrated that the workforce has the qualifications and knowledge or is trained, equipped and supported to effectively perform their roles and deliver the outcomes required by these standards.

I find that the approved provider is non-compliant with requirements 7(3)(c) and 7(3)(d).

**Standard 8**

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

**Findings**

The following requirements 8(3)(c), 8(3)(d) and 8(3)(e) were found non-compliant following a Site Audit in May 2022. The service has since appointed an aged care consultant to assist with implementing workflow and governance systems, including assistance with developing a suite of policies and procedures. The service was unable to demonstrate how its incident management system supported staff to understand, manage and prevent risk.

During this Assessment Contact from 21 March 2023 to 22 March 2023 the service demonstrated that it has commenced the process of implementing governance systems in relation to information management, a plan for continuous improvement, regulatory compliance, and feedback and complaints. It was found during the previous Site Audit that the Board has an established financial and governance sub-committee to provide a strong oversight of income and expenditure within the organisation. However, the service was unable to effectively demonstrate that the systems currently being implemented are operating consistently in accordance with the Aged Care Quality Standards.

The Assessment Team identified that staff have access to relevant information from several sources such as progress notes, care plans, emails, meeting minutes, and relevant training, however compliance rates for the service’s training program is not consistently monitored or followed up by management.

Management and staff confirmed that access to electronic information management and reporting systems is password protected to ensure the privacy and confidentiality of consumers’ information. Management stated that staff have electronic access to the current organisation’s policies and procedures, although several policies are currently in draft, such as its open disclosure policy, which requires ratification by the Board before being implemented and made accessible to staff.

The service provided evidence that it has recently developed an internal audit program to monitor and review its performance against the Aged Care Quality Standards. However, the program commenced in January 2023 and management was unable to effectively demonstrate that it reviews quality performance and clinical indicator data, consumer feedback/complaints, and incidents, to ensure a culture of continuous improvement at the service.

Management stated, and roster records confirmed, that there is always a registered nurse on site during daytime shifts, and that they assume an on-call role at all other times. The service manager regularly works as a registered nurse at service level and has assumed the role of Infection, Prevention and Control (IPC) Lead at the service. However, they have not yet commenced the IPC Lead course, which indicates that the service does not yet have a qualified IPC Lead to meet its current legislative obligations.

The service has a complaints/feedback register, but management was unable to demonstrate how it provides consistent oversight of daily service activities, progress notes, and resident meeting minutes to ensure that all complaints and feedback are captured and actioned accordingly.

The service is in the process of implementing several actions in response to the non-compliance identified during that Site Audit, however, does not yet have an effective incident management system or adequate clinical oversight of high impact, high prevalence risks to consumers living at the service.

The Assessment Team found that management and clinical staff demonstrated an adequate understanding of identifying and responding to incidents and of the SIRS reporting process, although one care staff member did not have a clear understanding of what constitutes a reportable incident. However, when the Assessment Team requested access to the service’s incident register and any incidents reported to SIRS in the last 6 months, management and staff were unable to produce those records, and were unsure whether any SIRS reports had been lodged during that period.

The Assessment Team reviewed the training program provided for all staff which includes topics on high impact high prevalence risk, and minimising restrictive practices, although the courses conducted on those subjects have a current compliance rate below 65%, with no follow-up from management at this stage with staff who have not yet completed that training. The training register reviewed by the Assessment Team indicates that education on the SIRS, falls, elder abuse and wound care scheduled for March 2023 has either not yet occurred, or not been recorded, which may impede management’s oversight of staff compliance and competencies in these areas of practice.

The organisation has recently attained a suite of policies and procedures from an external provider and is currently editing those policies and procedures to ensure they are specific and relevant to the service. The service is in the process of developing a clinical governance framework, although consumer safety and quality improvement systems are not yet fully established and operational. The service’s newly established clinical governance committee has commenced regular meetings, but management indicated that it is still in the process of formalising and implementing its clinical governance framework for the service.

The Assessment Team interviewed staff and found clinical staff were not able to adequately describe non-pharmacological measures taken to reduce urinary tract infections. A review of the service’s training schedule indicates that antimicrobial stewardship training is planned for August 2023, but there were no records made available to the Assessment Team that indicated staff have recently completed training on the subject.

All clinical and care staff interviewed were not able to clearly define all the elements of restrictive practice as it applies to their occupational environment, or their professional responsibility when applying a restrictive practice as a last resort.

The approved provider responded to the Assessment Team’s report and provided a copy of their Continuous Improvement Plan and copies of the fortnightly reports, Quality Indicator report to the Commission and the Board, (noting that there was inaccurate information related to pressure injuries), clinical governance framework and training records for some staff. The provider also advised that the Nurse advisor in place is undertaking the IPC lead until the manager completes the IPC course.

I acknowledge the actions that the provider has initiated since the Site Audit of May 2022 and the governance documents that are being developed, however I understand that it will take some time to reflect that there is effective organisational, risk management and clinical governance to inform and support staff with their practical knowledge and understanding.

I find that the approved provider is non-compliant in requirements 8(3)(c), 8(3)(d) and 8(3)(e).

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