Performance

Report

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| Name of service: | Catholic Healthcare St Paul's Residential Aged Care |
| Service address: | 27 Eastern Valley Way Northbridge NSW 2063 |
| Commission ID: | 1001 |
| Approved provider: | Catholic Healthcare Limited |
| Activity type: | Site Audit |
| Activity date: | 28 March 2023 to 30 March 2023 |
| Performance report date: | 3 May 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 Catholic Healthcare St Paul's Residential Aged Care (**the service**) has been prepared by T Wurf, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received on 20 April 2023 that accepted the findings in the Site Audit report
* the Performance Report dated 23 November 2022 following the Assessment Contact – Site visit undertaken on 27 October 2022, where 8 requirements were found to be non-compliant
* the Performance Report dated 6 August 2021 following the Site Audit undertaken from 19 May 2021 to 27 May 2021, where 10 requirements were found to be non-compliant, and
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Other relevant matters

The Performance Report dated 6 August 2021 following the Site Audit undertaken from 19 May 2021 to 27 May 2021, found 10 requirements to be non-compliant; 2(3)(a), 3(3)(b), 3(3)(g), 4(3)(a), 4(3)(b), 5(3)(b), 7(3)(a), 7(3)(c), 8(3)(a), and 8(3)(d).

An Assessment Contact visit was undertaken on 27 October 2022 to reassess those requirements found non-compliant following the Site Audit undertaken in May 2021. The Performance Report dated 23 November 2022 for the Assessment Contact found:

* requirements 5(3)(b) and 8(3)(a) were compliant, and
* requirements 2(3)(a), 3(3)(b), 7(3)(a), 7(3)(c) and 8(3)(d) were non-compliant.

Requirements 3(3)(g), 4(3)(a) and 4(3)(b) were not assessed.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and their representatives said that staff treat consumers with kindness, and make consumers feel respected and valued as an individual.

Consumers said they are provided with information that enables them to exercise choice and said staff are easy to talk to and keep them well informed. Staff described various ways in which information is provided to consumers, including about meal options, activities and outings. Monthly consumer meetings and quarterly consumer advisory committee meetings are held at the service. Information in different languages is available to consumers.

Consumers felt supported to take risks, such as smoke. Staff described how they support consumers to take risks and to minimise the risk of harm. Assessments are conducted to assess levels of risk to consumers and strategies are documented to manage the risks.

Staff knew consumers’ individual backgrounds, interests, needs and preferences, and described how they adapt care and services for individual consumers to ensure the consumer feels valued and safe. They also described their role in supporting consumers to maintain relationships that are important to them.

Care planning documents reflected consumers’ individual backgrounds and preferences, the people important to them, and who to involve in decisions about their care.

Consumers said their personal privacy is respected and confidentiality of their personal information is maintained. Staff described strategies to maintain consumer privacy and confidentiality, which was consistent with consumer feedback.

The Assessment Team observed:

* staff engaging with a consumer during a period of distress in a caring and patient manner
* notice boards advising consumers about upcoming events and daily activities, and menus displayed in the dining room
* staff knocking on consumers’ doors prior to entering, and
* consumer information was securely stored; electronic information was password protected and offices were kept locked.

# 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

Consumers and their representatives were satisfied with the service’s assessment and planning processes and said staff involve them in discussions about assessment, planning and review of care and services. Consumers and representatives reported that staff explained relevant information, communicate changes with them, and that they can access the consumer’s care plan and other care documents if they wish. They also spoke about how they can initiate changes to care plan information and the involvement of other health professionals such as psycho-geriatricians and wound specialists.

Registered staff understood the service’s assessment and care planning processes. Management and staff said assessment and planning are done in consultation with consumers, representatives, and other health professionals, such as allied health, dementia services, mental health services, geriatricians, medical officers and nurse practitioners. Staff advised they have access to consumers’ care documentation.

End-of-life care planning is discussed with consumers and representatives on entry to the service, during regular care plan reviews, and if a consumer’s condition deteriorates. Consumers’ end-of-life care wishes and preferences were documented.

Care documentation reviewed by the Assessment Team evidenced comprehensive assessment and care planning that identified consumers’ needs, goals, and preferences, as well as regular review of care and services. Risks to individual consumers’ health and well-being were identified, documented and managed. Risks included falls, diabetes, wounds and skin integrity, and strategies to manage these risks were documented. Care documentation evidenced the involvement of other health professionals, such as medical officers and health specialists, and review on a regular basis including when circumstances changed and or when incidents occurred.

The service has policies and procedures to guide staff in assessment and care planning processes.

*Requirement 2(3)(a)*

The Performance Report dated 23 November 2022 found the service non-compliant with requirement 2(3)(a) following an Assessment Contact visit undertaken on 27 October 2022, based on deficiencies in assessment and care planning processes. For example:

* Care planning information was inconsistent and not reflective of the consumer’s condition.
* Comprehensive assessments were not undertaken.
* Recommendations from specialists were not implemented and/or monitored.
* Management of incidents, pain and post-fall observations were ineffective.

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in this requirement. Improvements included:

* The clinical team reviewed all consumers’ assessments and care plans.
* Established regular monitoring to ensure assessments and care planning are completed (weekly monitoring by the care manager and monthly by the regional quality manager).
* Implemented a register for care plan review and case conferences to ensure these occur when due.
* Delivered assessment and care planning training to registered staff and management.
* Conducts surveys of consumer satisfaction with care planning.

I am satisfied the deficiencies with the service’s assessment and planning have been remediated.

Based on the findings contained in the Site Audit Report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   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. | 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

Consumers and their representatives were satisfied with the care and services consumers receive, and consumers’ needs and preferences are effectively communicated between staff.

Staff said they have access to the information they need about consumers, including in the service’s electronic care management system and shift handover.

The Assessment Team reviewed a sample of consumers and found care planning documentation was individualised and safe. For example:

* A consumer with a wound was monitored by a registered nurse, had the wound consistently attended to in accordance with directives in care documentation and the wound was improving. Staff understood various strategies for pressure injury management.
* Care documentation for another consumer with a complex health condition and care needs identified care and monitoring had been delivered as per the care directives.
* Where restrictive practices were used, consent, authorisation, and behaviour support plans were in place.

Care documentation reflected management of high impact, high prevalence risks to consumers, such as complex behaviours, falls, wounds, unplanned weight loss and pain. Staff described the main risks to consumers and associated strategies in place to manage those risks. Consumers with high risks were reviewed regularly by management and registered staff. Clinical incident data was analysed and reported within the organisation.

Care documentation included consumers’ end-of-life needs and preferences, advance health directives, and a palliative care plan where required. Staff understood the palliative care pathway and resources available to them to support consumers nearing the end of life.

Care documentation demonstrated staff recognise, report and respond to changes in a consumer’s condition. Clinical staff described assessment, discussion with the consumer/representative and referrals to medical officers, allied health professionals or hospital as required.

The service makes referrals to other organisations and providers of care, such as allied health professionals, medical officers, specialist dementia services, geriatricians, palliative care consultants and wound specialists.

The service has policies, procedures and an outbreak management plan to guide staff in relation to infection control practices, management of an infectious outbreak and antibiotic management. The service has a vaccination program and two Infection prevention and control (IPC) Leads. The Assessment Team observed staff using personal protective equipment, practicing hand hygiene appropriately, and screening people entering the service. Infections and outbreaks are analysed and reviewed monthly.

*Requirement 3(3)(b)*

The Performance Report dated 23 November 2022 found the service non-compliant with requirement 3(3)(b) following an Assessment Contact visit undertaken on 27 October 2022, based on:

* deficiencies in the management of incidents presenting high impact risks for consumers, and
* strategies to manage risks were not implemented and/or monitored for effectiveness.

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in this requirement, including:

* Education for registered staff on various topics related to assessment and management of risk.
* Established processes to monitor the management of incidents.
  + Daily monitoring of incidents to check whether staff have followed the process.
  + Monthly spot checks of care documentation to ensure strategies to manage risk were implemented and evaluated for effectiveness.
  + Where issues were identified, the service took corrective action.

*Requirement 3(3)(g)*

The Performance Report dated 6 August 2021 found the service non-compliant with requirement 3(3)(g) following a Site Audit undertaken from 19 to 27 May 2021, based on deficiencies in the service’s infection control practices.

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in this requirement. Actions included:

* Reviewed screening protocols to ensure that staff, contractors and visitors to the service are screened on entry via a questionnaire and health declaration and rapid antigen test. Visitors are also educated in hand hygiene and the use of personal protective equipment.
* Labelled bins to distinguish between clinical and general waste.
* Engaged two IPC leads.
* Reviewed outbreak management plans.
* Implemented infection control compliance spot checks and monitoring.

I am satisfied the deficiencies in the service’s practices to minimise infection-related risks have been remediated.

I am satisfied the service has remediated the deficiencies previously found in relation to requirements 3(3)(b) and 3(3)(g). Therefore, based on the findings contained in the Site Audit Report and the improvements made by the service, it is my decision that each requirement in Standard 3 and the overall quality standard are compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers and their representatives said consumers are supported to engage in activities of interest to them and are provided with relevant supports, such as equipment and resources. Consumers said the service supports their emotional, spiritual and psychological well-being. Consumers spoke about being supported by the service to participate in meaningful activities both within and outside the service, such as community outings, visiting family and friends, exercise programs, social gatherings, service group activities and individual activities.

Consumer care documentation was individualised and reflected what was important to them, information about their life history, and lifestyle activities of interest. Staff were familiar with this information and how to support individual consumers, including to maintain relationships with people important to them and participate in activities of interest. Staff also spoke about one-on-one engagement for those consumers that prefer individual rather than group activities.

Consumers and representatives were satisfied that information is effectively communicated between staff. Management and staff said there are processes to communicate consumers’ information. The service makes referrals to other services and engages external organisations to support consumers, including local churches and community groups.

Consumers and representatives were satisfied with the meals provided by the service and said they provide feedback on the menu. Consumers are offered choice of meals and alternative options are available to them. Consumers’ dietary requirements and preferences are known by staff. Consumers provide input into the menu at consumer meetings and food focus meetings and the chef seeks daily feedback from consumers.

Consumers said the equipment is safe and they know how to report any concerns or issues. The service has processes for purchasing, servicing and replacing equipment. Equipment used to support consumers to engage in lifestyle activities was observed to be suitable, clean and well-maintained.

*Requirements 4(3)(a) and 4(3)(b)*

The Performance Report dated 6 August 2021 found the service non-compliant with requirements 4(3)(a) and 4(3)(b) following a Site Audit undertaken from 19 to 27 May 2021, based on deficiencies in:

* staff knowledge, care documentation and service delivery relevant to consumers’ needs, goals and preferences for services and supports for daily living; and
* emotional, spiritual and psychological support for some consumers.

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in these requirements, including:

* Reviewed and updated consumers’ lifestyle and leisure assessments and care plans.
* Providing weekly and annual activities calendars to consumers.
* Evaluated the service’s activity calendar and updated it to include outdoor activities such as bus trips, barbeques in the garden and gardening groups.
* Included lifestyle staff in daily management meetings and consumer case conferences.
* Sought feedback from consumers about their interests and activities via a survey, consumer meetings, and a lifestyle forum.
* Trained staff on person-centred care, emotional support, privacy and dignity.
* Provided resources for consumers to access at any time as an alternative to the main activity being offered.

I am satisfied the deficiencies in the service’s management of services and support for daily living have been remediated. Based on the findings contained in the Site Audit Report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers were satisfied with the service environment and reported:

* they enjoy spending time inside in communal areas and outside in the courtyard
* an improvement in cleaning, and that consumers’ rooms and common areas are clean and well-maintained, and
* maintenance attends promptly to issues.

Staff demonstrated effective processes to ensure the environment is safe, well maintenance and clean.

The service equipment, fittings and furnishings were observed to be well-maintained, clean and safe for consumers. Cleaning and maintenance tasks are scheduled and monitored daily. Maintenance staff have preventative and reactive maintenance schedules and maintenance is attended to in a timely manner.

The Assessment Team observed:

* the environment to be warm, welcoming, and easy to navigate with detailed signage, wide corridors and handrails
* consumers’ rooms to be spacious and personalised with photographs, furniture and memorabilia
* consumers participating in and watching activities throughout the service and using the service’s courtyard, library and activities areas
* consumers moving freely in indoor and outdoor areas
* the smoking area to be equipped with fire safety equipment, and
* equipment and furnishings throughout the service to be clean, including in the kitchen and laundry.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives said they:

* felt encouraged, safe and supported to provide feedback and make complaints, including directly speaking with staff and management and providing feedback during meetings
* were familiar with their access to external mechanisms for raising and resolving complaints and advocacy services, and
* were satisfied with the actions taken in response to the complaints. They said their complaints were resolved quickly and improvements were made at the service in response to their feedback

Staff described their role in the service’s complaints management processes, including supporting consumers/representatives to raise feedback and complaints and access external complaints bodies. Management identified various avenues from which complaints and feedback are actively sourced, including surveys, meetings and verbally from staff, consumers and others. Open disclosure is understood and used by staff in response to complaints and when things go wrong.

The service uses feedback and complaints to improve the quality of care and services. The service’s feedback and complaints register and plan for continuous improvement documents feedback and complaints, timely actions taken to resolve complaints and improvements made as a result of feedback and complaints.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Consumers and their representatives provided positive feedback about staff. Consumers said staff:

* are available when needed and attend promptly to requests for assistance
* are kind, caring and treat consumers well, and
* do their job well, and are skilled, knowledgeable, well-trained, and competent in providing care and services that meet their needs.

Staff considered there was enough staff to deliver care and services in accordance with consumers’ needs and preferences, and they have enough time to complete their allocated tasks and spend individual time with consumers to “have a chat”. Staff demonstrated a solid understanding of individual consumers’ backgrounds, needs and preferences.

Management said the service has a staff roster coordination team that ensures all shifts are filled. The staff rosters for the two-week period prior to the Site Audit showed all shifts were filled and there was minimal use of agency staff. Management advised that call bell response times are monitored daily by management and certain responses are investigated and actioned where required.

The performance of the workforce is monitored and reviewed. The service determines staff competency through processes such as skills assessments, performance appraisals, consumer/representative feedback and complaints, annual consumer experience surveys, audits, observations and review of clinical records.

The service has processes to recruit, train and support the workforce. Position descriptions are available for various roles. The service has processes for monitoring staff criminal record checks, professional registrations and vaccinations. New staff receive orientation, are buddied with more experienced staff, and complete online mandatory training and competency assessments. Agency staff are allocated a permanent staff “buddy” on each shift. Consumers, agency and permanent staff expressed confidence in the competency of agency staff. Staff receive training and competency assessments relevant to their role.

The Assessment Team observed:

* kind, caring and respectful interactions between staff, management and consumers, and
* staff responding promptly to requests for assistance from consumers.

*Requirements 7(3)(a) and 7(3)(c)*

The Performance Report dated 23 November 2022 found the service non-compliant with requirements 7(3)(a) and 7(3)(c) following an Assessment Contact visit undertaken on 27 October 2022, based on deficiencies in:

* agency staff knowledge and competency, and
* staff competency and skills, including in incident management, assessment and planning, and management of complex behaviours, and
* completion rates in some areas of staff mandatory education and competency assessments.

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in these requirements, including:

* Recruited additional permanent nursing and care staff, which has led to a decrease in unplanned leave and the need for agency staff.
* Engaged a preferred agency to supply regular agency staff.
* Agency staff are allocated a permanent staff “buddy” on every shift, complete orientation and induction, and are allocated time to sit with consumers to get to know them.
* Implemented a training system to ensure staff competencies and mandatory training are completed.

I am satisfied the deficiencies in staff knowledge, competency and skills have been remediated. Based on the findings contained in the Site Audit Report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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

Consumers and representatives were confident the service is well run and they can provide feedback and suggestions about care and services directly to staff and management. A consumer and management described how consumers are involved in staff recruitment processes. Consumers and their representatives spoke positively about the service’s management of information, care and risks to consumers.

The organisation’s governance framework identifies a leadership and accountability structure. The Board of Directors comprises members experienced in clinical health care, governance, finance, and risk management. The Board is kept abreast of the service’s operations via executive and governance teams who provide monthly reports.

The service has effective governance systems and processes relating to information management, continuous improvement, financial governance, workforce management, regulatory compliance and feedback and complaints.

The service promptly responds to risks that are identified across the care and service continuum. The service has a documented clinical governance framework, policies and procedures that guides how the service manages risk, incidents, antimicrobial stewardship, restrictive practices, and open disclosure. Staff receive training on various topics that relate to risk and clinical governance and demonstrated an understanding of these areas relevant to their role. The service’s management staff provide clinical oversight of staff delivering clinical care to consumers.

*Requirement 8(3)(d)*

The Performance Report dated 23 November 2022 found the service non-compliant with requirement 8(3)(d) following an Assessment Contact visit undertaken on 27 October 2022, based on deficiencies in the service’s management of risk.

The Site Audit Report identified that the service has taken actions to remediate the deficiencies and improve its performance in this requirement, including:

* Established a training program that includes investigation, management and documentation of incidents, which was completed by all clinical staff.
* Established processes to monitor the management of incidents.
  + Daily monitoring of incidents to check whether staff have followed the process.
  + Monthly spot checks of care documentation to ensure strategies to manage risk were implemented and evaluated for effectiveness.
  + Where issues were identified, the service took corrective action.

I am satisfied the deficiencies in the service’s management of risk have been remediated. Based on the findings contained in the Site Audit Report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)