

**Performance Report**

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| Name: | Catholic Healthcare The Haven Residential Aged Care |
| Commission ID: | 2584 |
| Address: | 156 Bourke Street, WAGGA WAGGA, New South Wales, 2650 |
| Activity type: | Site Audit |
| Activity date: | 10 December 2024 to 12 December 2024 |
| Performance report date: | 15 January 2025 |
| Service included in this assessment: | Provider: 1191 Catholic Healthcare Limited Service: 955 Catholic Healthcare The Haven Residential Aged Care |

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 The Haven Residential Aged Care (**the service**) has been prepared by G. McNamara, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others
* the provider’s response to the Assessment Team’s report received 15 January 2025.

# 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.

# 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

Most consumers and their representatives said staff treat them with respect and make them feel valued. Staff described, with examples, how they ensure each consumer’s dignity and diversity is respected. Lifestyle staff described how the service ensures accurate cultural and identity information is gathered and pastoral care staff confirmed they regularly survey consumers about their experiences of dignity and respect at the service.

Consumers said service staff know their background and what is important to them. Care plans contained detailed, individualised information about how the service is to provide culturally tailored care. The service demonstrated use of bilingual service providers, a translation app and communication cue cards for linguistically diverse consumers. There is a cultural safety, diversity and inclusion policy. The service has a diverse staff profile.

All consumers reported they can make their own decisions about how their services are delivered, including about who assists in their decision making, when they shower, go to bed and where they want to take their meals. Consumers described ways the service supports them to make and maintain important relationships with people inside and outside the service. Care planning documents reflected key relationships of sampled consumers, and staff outlined how the service encourages visits, phone calls and video calls between consumers and their family and friends.

The service demonstrated effective ‘dignity of risk’ processes in place. The service identified consumers who wish to take risks, such as by smoking, leaving the service independently or by using specific mobility equipment. There was documented evidence that those consumers had been appropriately assessed and risks and safety strategies identified, to support consumers in making informed decisions. The Assessment Team found that a consumer had not had relevant risk assessments completed to support their decision to disregard dietary advice, however in its response the approved provider submitted evidence to indicate care documentation was reflective of the consumers situation and preferences, and that swallowing difficulties were subsequently determined and actioned in a timely manner.

The service demonstrated they provide information to consumers in a timely manner, to support their decision making about daily life and care. The service uses a variety of methods to support consumers with communication barriers, including translation apps, cue cards, communication boards and basic written, visual and verbal methods. Information packs provided on admission advise consumers about the day-to-day lifestyle activities, food services and religious services. Kitchen staff visit each consumer with the following day’s menu, to assist consumers to make their meal choices. Clinical staff provide information about medications and medical appointments to consumers and/or representatives.

Consumers reported their privacy is respected and observations during the audit corroborated this, with staff knocking and waiting to be invited into consumer rooms, for example. Care and clinical staff outlined ways they maintain consumer privacy during care provision, and how personal information is protected.

# 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

As to Compliant requirements 2(3)(a), 2(3)(c), 2(3)(d) and 2(3)(e).

The service demonstrated there is an effective assessment and planning process in place at the service, to inform delivery of care and service, which includes consideration of risks to consumer health and wellbeing. Consumers and representatives reported risks to their health and well-being were considered and they felt safe at the service.

Upon entry to the service, registered nurses follow an assessment and care plan guide to conduct required risk assessments, which inform care plans. For example, consumers with falls risk were identified and falls prevention strategies documented in care plans. Pressure injury risk was identified and care plans contained risk minimisation strategies. Electronic alerts flag specific consumer risks to staff when consumer files are accessed. When a consumer enters the service, the registered nurses have an assessment and care plan guide which they follow to conduct assessments from day one, including a falls risk and skin assessment.

Consumers and representatives confirmed they had been involved in their care planning and their needs were being met. They advised this involves other organisations and providers of care. Care and service documentation provided evidence of case conferences and the involvement of a range of other health providers such as medical officers, dementia services and physiotherapists. Staff gave examples of consumer preferences and recommendations for care including other providers of care.

It was noted that for a consumer some information provided by their representative was not observed in that consumer’s care plan. I have considered that information under Standard 2 requirement (3)(b).

Consumers and representatives confirmed they had been involved in case conferencing and some said they were offered a copy of their care plan. All consumers and representatives said staff communicated well with them about the care and services provided. The registered nurses said they report changes to families when changes occur, and provided examples.

Care staff said the registered nurses communicate changes in assessment and planning to them and they have access to care plans to provide recommended care and services.

Consumers and representatives said the staff inform them promptly when there is an incident or change in condition. Staff said they review care and services regularly and when circumstances change. Documentation indicated reviews were done regularly and after change or incidents. Care staff are notified of changes immediately after, for example, the physiotherapist notifies the registered nurse. They are also discussed during handover and morning and afternoon huddles at 11 am and 4 pm in the nurse’s station. The registered nurses said the care staff advise them of any changes in consumer’s condition. If a consumer is not eating or has a change in appetite, for example, the registered nurse said they would do an oral health assessment and monitor. This was evidenced in relation to a consumer sampled. The registered nurses said any changes in a consumers’ condition prompt a review. For example, after a fall they would do a falls risk assessment (FRAT), environmental assessment, skin assessment and pain chart. Care staff said they inform the registered nurses of any changes, and they report changes in the morning huddle. They said they complete a stop and watch form when they observe changes in consumers.

As to requirement 2(3)(b).

The Assessment Team found this requirement Not Met however, for the following reasons and on balance, I find this requirement Compliant.

Consumers and representatives provided examples of their current needs, goals and preferences and were satisfied these were being addressed by the service. They also confirmed they had discussed and provided information in relation to advance care planning. Staff were able to describe the current needs, goals and preferences of consumers. Information about consumers current needs, goals and preferences was discussed by staff during handover. The Assessment Team indicated consumer care plans evidenced some high-risk assessments are completed, including advance care planning and end of life planning.

However, the Assessment Team reported that some information about consumers’ needs, goals and preferences was not consistently documented in consumer care planning, which placed consumers at risk. For example, the representative of a consumer with diagnoses of a neurological disorder and dementia noted that the consumer had a skin disorder which is sensitive to heat and that staff were to notify the consumer’s medical officer when this occurred. The Assessment Team found this was not noted in that consumers skin or hygiene care planning. The representative also said the consumer receives therapies and treatments for pain in a particular part of their body, but this was not referenced in the consumers care planning documentation.

That consumer’s representative also stated they had spoken to a registered nurse and requested a bed sensor, and had requested staff to ensure the consumer could ingest medications were ingested, which they indicated staff were following up. The Assessment Team advised management of these matters who noted they would follow them up.

In relation to another consumer, the Assessment Team reported it was discussed in handover that a female consumer preferred female staff to provide her care, but this was not documented in her care plan.

The Assessment Team reported that these discrepancies in care planning documentation were discussed with management who was responsive, advising that advised care plans had been updated and a plan for continuous improvement (PCI) had been commenced which included a number of measures, including spot check and random reviews of 3 consumer care plans each month with feedback to registered nurses, related spot checks for lifestyle and pastoral care plans, and toolbox talks with all relevant staff.

The Assessment Team found that while management positively responded to the matters identified, the actions implemented would take time to put into practice at the service.

In its written response the approved provider acknowledged that the exact nature of the skin disorder identified by that consumer’s representative was not referenced in their care plan due to the outdated diagnosis list. However, it provided information to indicate that appropriate treatments were in place for his skin condition, including an oral tablet and a cream, which was evident in a medication summary. The provider also noted that medical notes and other documentation did not indicate a sensitivity to heat, and that the consumer’s representative indicated satisfaction with care provided. I note that this consumer’s initial care plan had limited instruction for staff to check the consumers skin for flare ups or referral to the GP, although it referenced related skin issues. The provider submitted an updated care plan with this detail.

I believe the original care plan could have been more detailed. However, I note that other documentation indicated treatments were in place to manage the skin condition. Further, the approved provider updated the care plan. The approved provider has demonstrated compliance with a large majority of other requirements; therefore, I am satisfied that this instance was not indicative of systemic concerns, that it has rectified this issue, and the improvements it outlined to the Assessment Team, in relation to care planning, will reinforce its care planning capabilities.

In relation to pain in a particular part of that consumer’s body, the approved provider submitted information, including a pain review post the site audit, which indicated that pain in that part of the body had not been complained about, identified or evident, and provided supporting documentation. It stated that it was unaware of the complaint of pain in the stated area as this was never raised by the consumer’s authorised representative or the consumer. The approved provider noted that the consumer was charted on regular analgesics for aches and pains and PRN topical analgesic gel for pain in another area of their body. Medication charts confirmed this. I am unable to come to a positive finding that the care documentation was deficient in this regard.

In relation to a bed sensor, information from the approved provider indicated discussions had previously been held about use of a bed sensor with a decision it may be counterproductive. While these discussion were not explicitly documented, including whether this was agreed to by all parties, it appears this had been earlier discussed. Documentation indicated discussions were held post the site audit, with a bed sensor now in place. The approved provider is encouraged to consider improvements in documenting discussions on care and service requests

In relation to the ingestion of medications, information from the approved provider indicated the consumer had no physical swallowing difficulties, with the issue being related to other matters, which were identified in the care plan.

In relation to a female consumer preferring female staff to provide her care, documentation submitted by the approved provider indicated that prior to the site audit this preference was contained in a care alert and a continence and toileting plan, which the approved provider indicated was part of the overall care plan.

In concluding that this requirement is Compliant, I have also considered that the approved provider has demonstrated compliance with all other requirements in relation to this service, which indicates generally robust systems and processes, that it has rectified identified, individual issues, its responsiveness to the issues identified, and that its Plan for Continuous Improvement (PCI) is comprehensive and likely to be put into effect.

I have also considered the Assessment Team’s findings that consumers were being provided with the appropriate care and that staff were well informed and knowledgeable about consumer needs.

# 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

Review of care and service records, observations made and interviews with management and staff showed safe and effective care is provided.

Consumers and representatives said they were satisfied with the care and services provided to them at the facility.

A review of incident reporting in clinical documentation indicated the service is providing best practice care after falls which optimises the health and well-being of consumers. An example was cited of the steps taken following a consumer experiencing an unwitnessed fall resulting a in fracture.

Regarding restrictive practices, the service provided a completed psychotropic self-assessment tool. This indicated there are 9 consumers who are considered chemically restrained and confirmed the response to the risk-based question during the entry meeting to the Site Audit. Review of clinical documentation, observations and interviews with staff indicated that chemical restraint is administered after other strategies are undertaken.

Consumers and representatives reported they are satisfied with the management of medications at the service, and that consumers receive the right medication at the right time and are given assistance to take the medication when required. Records of known allergies were consistently documented in reviewed consumer files. Staff said they check the medication trolleys every Sunday for out-of-date medications or low stock. The registered nurse on night shift also checks the medication trolleys.

In relation to wound management, it was noted a consumer’s wound was healing with the wound being photographed and dressed every 4 days, and documented in a wound chart. However, wound measurements were not being altered as the wound heals and changed. This was addressed as a continuous improvement exercise by the approved provider. In its response the approved stated that the wound chart was not completed once within the 8 day period, explaining this occurred due to an acute chronic episode for this consumer, unrelated to wound care, at this time.

Consumers who experience unplanned weight loss are referred to a dietitian, provided with nutritional supplements, their food and fluid intake is monitored, and monthly weighing is charted and easily accessed on the electronic clinical management system.

Staff advised preferences with time of showering, oral hygiene and activities are discussed with consumers and their families and documented in their care plan. Care staff advised they replace consumer toothbrushes seasonally.

The service has systems in place to manage high-impact, high-prevalence risks. The organisation has a suite of policies and procedures in relation to high-impact, high-prevalence risks and risk management. The policies incorporate dignity of risk and information in relation to choking, diabetes, medication safety, managing delirium and other risks, and links to other policies related to that risk.

There are 2 care managers who advised they review all progress notes every morning. There is a report provided by the registered nurses from evening and night shift which documents all falls or other incidents, including hospital transfers. The care managers do a daily round of the service including unwell consumers and those post incident. They check the list of high-risk profile consumers; this list is created by the electronic clinical management system.

A resident risk profile is used to categorise consumers into high, medium and low risks. There is a management meeting every day at 9:30 am and new admissions and incidents, consumers who are deteriorating and their care are discussed.

Staff said they are told about high-impact high-prevalence risks every day. The service identified skin tears, wound management and falls as their leading high-impact high-prevalence risks. Consumers and representatives provided positive feedback about how the service is managing their risks, for example, in relation to management of falls risks by use of bed sensors and half hourly checks.

The physiotherapist said they review consumers who have had a fall, and also said they have a falls meeting every Friday. The physiotherapist described how the service monitored falls which showed increasing number of days between falls at the service. This has been supported by staff education and awareness of falls prevention.

Management advised there were 2 consumers with pressure injuries at the service during the entry meeting, and detailed how these were monitored and managed. A consumer stated they were very happy about how the service has been managing their chronic wound. The service maintains a wound report, which details type of wound or bruising injury and management strategies.

Staff at the service described how they manage skin integrity by repositioning consumers and using moisturiser for consumer’s skin. They said they check the consumer’s skin during personal hygiene and report any bruising or changes to the registered nurse.

Consumers’ files showed advance care plans have been completed. Staff were able to describe how care changes when a consumer approaches their end of life and expressed compassion. Staff said they ensure consumers are kept comfortable. The organisation has a suite of policies and procedures in relation to palliative and end of life care.

There were no consumers who were receiving end of life care during the Site Audit; however, the file of a recently deceased consumer was reviewed, and their representative interviewed by the Assessment Team. That information evidenced compassionate and appropriate management of the emotional and physical aspects of that consumer’s passing, with their surviving spouse articulating the empathetic and informed support given to them and their spouse.

Consumers said they were confident any changes in their condition would be picked up and responded to by the staff at the service. Representatives confirmed the service is responsive if their relative is unwell and notifies them of any changes as they occur.

The service uses a stop and watch tool for staff to alert the registered nurse in addition to verbal notification when they observe change in mobility, pain, appetite or other changes. The stop and watch is documented in the consumer’s file, the registered nurse is then alerted and will follow up. Care staff said they identify deterioration or change in a consumers condition by monitoring for changes in consumer mobility or behaviour, and use the stop and watch tool, and report to the registered nurse verbally. This was evidenced in relation to consumer’s reviewed.

Clinical staff described assessments used to identify change in a consumers condition including physical triggers such as delirium, pain, and infection, and when consumer’s experience behavioural changes. This was shown in relation to a consumer complaining of lower back pain.

There are processes in place to document and communicate information within the organisation and with others where responsibility for care is shared. Representatives said staff communicated well with them about the consumers condition and needs. Staff were aware of consumer preferences, condition and needs.

Appointments are documented in notes to inform handover by the registered nurses. Consumer notes are accessible in summary in relation to consumer’s with appointments coming up including, in one example, details of the need to cease certain medications 2 days prior to an appointment, and transport details.

Staff advised they receive and share information about consumer’s condition, needs and preferences at handover and huddles daily. Staff document activity logs daily within the electronic clinical management system. This includes showering and charting blood glucose levels, bowel and sight charts. Notes written by the dietitian and medical officer were observed to be documented in clinical files.

Consumers said they felt they were referred to doctors and specialists when required and confirmed input from allied health services such as the physiotherapist. Consumer files indicated referrals for consumers had occurred in an appropriate manner. For example, one consumer was observed to be visited by Dementia Support Australia. Another was reviewed by a speech pathologist when they were deteriorating and experiencing swallowing difficulty.

The organisation has processes in place to monitor infections and antibiotic use. Consumers and representatives interviewed said they were satisfied with how the service has managed the minimisation of infection related risks. Medical officers attend vaccinations for their own consumers at the service and the vaccinations are recorded in consumer medication charts. The service runs a vaccination clinic for staff influenza vaccinations once per year. There are 2 infection prevention and control (IPC) leads at the service. Infections and antimicrobial stewardship are standing agenda items at the medication advisory committee (MAC) meeting.

Management is notified when consumers present with infectious symptoms and when antibiotics are commenced, which is discussed in risk meetings. The service has policies and procedures to guide staff in relation to respiratory outbreak and antimicrobial stewardship. Staff demonstrated an understanding of how they minimise the spread of infection including hand hygiene principles, for example, through regular handwashing and using sound hygiene practices when delivering care to consumers.

Staff were aware of the principle of antimicrobial stewardship and obtaining pathology results before commencing antibiotics, use of appropriate personal protective equipment (PPE) when there is a risk of contamination from body fluids, and caring for consumers in isolation until a negative test is received when an infectious illness is suspected.

Management advised the service had a COVID-19 outbreak in November 2024.The outbreak was disclosed to the Public Health Unit (PHU) following a second positive test result. The PHU guidelines were followed. The IPC lead described how they discuss infections at the ‘9 at 9’ management meeting. Infections are included in monthly audits.

The service has access to adequate stock of COVID-19 and influenza antivirals. Hand washing stations and hand sanitiser is available for use throughout the service. Notices displaying the correct handwashing procedures are posted around the service.

# 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

As to Compliant requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(e), 4(3)(f) and 4(3)(g).

Each consumer gets safe and effective services and supports for daily living that meets their needs, goals and preferences and optimises their independence. Assessments are undertaken on entry to the service to capture consumer interests, and regular consultation is undertaken with consumers to ensure supports, services and activities are suitable and meeting the consumer’s current needs. For example, one consumer representative said showering times have been chosen by them to ensure the consumer is up, showered, and dressed before their treatment session commences. Knowledge of and respect for other personal choices was seen for other consumers.

Care and clinical staff advised that to maintain consumer independence they encourage consumers to do what they are able, such as eating, washing, or dressing, and will assist when needed. Clinical staff and management said consumers always have a choice of how supports and services are delivered, and information gathered on admission includes the consumer’s preference to supports including the time they would like their showers, their preferred gender of staff undertaking care, and what time they like to go to bed. This information is recorded on their care plans.

Services and supports for daily living promote each consumer’s emotional, spiritual, and psychological well-being, which is holistic based using internal supports and external organisations and individuals. All consumers indicated they felt their emotional, spiritual, and psychological well-being was being supported in relation to, for example, pastoral care following the passing of a family member. Pastoral care staff advised they receive referrals from clinical or care staff in an email, and that also includes religious services of a consumer’s choice.

Clinical, care, pastoral and lifestyle staff spoke about how they identify when consumers were feeling low, and described signs indicating a change in the consumer including lack of engagement with staff, loss of appetite, or a reduction in their participation of activities.

Consumers are provided opportunities to participate within the service and broader community or undertake things that are of interest to them. Feedback from consumers and representatives is used to identify activities, supports and services. Consumers can pursue social and personal relationships, which was evidenced in consumer files.

Cessation of bus outings was discussed with management, which had been reinstated. Lifestyle staff advised risk assessments are undertaken for venues prior to each bus activity, and the Assessment Team sighted signed risk acknowledgement forms from consumers partaking in the bus outings.

The service ensures timely and appropriate referrals to individuals, other organisations and providers of other care and services. Consumers and representatives interviewed did not identify any concerns regarding the lack of referrals to individuals and other organisations. Clinical, care, pastoral and lifestyle staff could all discuss referrals to other organisations and providers of care and services. For example, Lifestyle staff and management advised they were able to liaise and refer consumers to other individuals and supports, when necessary. Examples were evidenced.

The Assessment Team sighted referrals to other organisations, including DSA, and Red Cross volunteers were observed talking to consumers.

Meals provided are varied and of suitable quality and quantity, and consumers with dietary needs and preferences were catered for. Care staff and management advised consumers have choice, and alternatives are provided if needed. Meals are cooked fresh onsite.

Consumer and representative feedback regarding meals was mixed. All consumers interviewed said there was enough food and they never felt hungry. Consumers said there was a choice of food, and if they did not like what was being served, they could ask for an alternative. One consumer stated the meals provided were often cold, vegetables not cooked through and are too hard, and said meals are often delivered late, however that consumer stated staff come in every day to take her order for their meals, and ask them if they would like an alternative choice if they were unhappy with the menu. Another consumer said the food is sometimes cold, but there is always enough to eat, and she has never been hungry. Another consumer said all meals are served warm, and a particular dish was the best they had ever had.

Kitchen staff could provide evidence consumers are provided alternative meals from the menu. The Assessment Team sighted the daily meal preparation sheet, and noted that particular requests or alternative meals were accommodated.

Kitchen staff said they have a seasonal menu which has been developed across all Catholic Healthcare sites. Each site modifies the menu to enable meals to be site specific and meet consumer needs. Menus are rotated every 4 weeks. Consumers are provided a choice of meals including protein and vegetarian, however, displayed menus in the dining room did not match meals presented, and this was raised with management who reminded staff that menus required changing.

Management advised the consumer dining experience was important, and showed evidence new menus in development will contain visual representation of the meal. The service has planned future training including table preparation for consumer meals. The Assessment Team sighted a set table in the training room in preparation for training.

The service could demonstrate feedback is actively sought on the quality of meals, consumers were consulted in menu preparation, and all complaints received regarding meals were handled appropriately.

The service has a ‘Resident Food and Menu Forum’ and a ‘Resident and Authorised Representative’ meeting. The Assessment Team noted consumers were provided the opportunity to discuss the menu and incorporation of monthly cultural lunches in the ‘Food and Menu Forum,’ and meals and menus were discussed at the ‘Resident and Authorised Representative’ meetings, including reviewing suggestions for improvements.

The lunch meal service was observed in 2 dining rooms. Consumers were calm and socially engaged with each other. The Assessment Team noted fridges in the kitchenette areas available to consumers, which contained drinks, soft foods, and fruit.

On balance I find requirement 4(3)(f) compliant, but encourage the approved provider to consider consumer feedback above in relation to food temperature, quality and delivery time, for the purpose of continuous improvement.

Equipment provided is safe, suitable, clean and well maintained. Consumers and staff confirmed there is sufficient equipment which is well maintained. Maintenance staff could demonstrate equipment is maintained and serviced regularly.

Consumers said equipment such as call bells are working, and equipment used is suitable and maintained. One representative advised the bed mattress had broken, and this was repaired almost immediately. All equipment provided to the consumer is new, and the service was investigating the purchase of additional equipment including a wheelchair to enable further mobility.

Maintenance staff could demonstrate equipment such as beds, call bells, wheelchairs, weigh chairs and lifters are tested, repaired, or calibrated regularly by maintenance staff or external providers.

Care staff reported if they identified any concerns regarding consumer equipment, they would log the issue so it can be examined and repaired. Care and clinical staff advised powered equipment is charged after use, and it is the responsibility of the afternoon shift to ensure all equipment is charged. Cleaning staff reported wheelie walkers, beds, and other consumer equipment, is cleaned on the rostered deep clean days. If equipment has been noticed to be unclean, cleaning staff will give it a wipe over.

The Assessment Team sighted the equipment testing and maintenance schedule, and noted while there were several outstanding items, the service could demonstrate these had been actioned and were awaiting completion by external providers.

As to requirement 4(3)(d).

The Assessment Team found this requirement Not Met however, for the following reasons and on balance, I find this requirement Compliant.

The service undertakes regular consultation with consumers to ensure supports, services and activities are suitable and meeting the consumer’s current needs, however the Assessment Team found that, while care is being safely provided, care planning documentation sighted did not always identify how the service would meet consumer health and well-being goals. For example, one consumer’s spouse had recently passed away, however this was not reflected in the surviving spouse’s pastoral and lifestyle care plans. When raised with management, the care plans were updated immediately.

Another consumer stated they maintained close contact with family, and described the activities they liked outside the service. The Assessment Team found that their lifestyle and pastoral care plans contained minimal information, and information including ‘about me’ and ‘life history’ was blank. This was raised with management who provided evidence the information had been collected, but had not yet been incorporated into their care planning documentation.

The Assessment Team found that another consumer was observed undertaking a particular social activity which staff confirmed occurred each day. A review of that consumer’s lifestyle care plan contained minimal information, and did not reference the observed and known social activity. When this was raised with management their care plan was updated to better reflect their needs and preferences.

I have considered these findings in relation to these consumers later in this requirement.

Care and clinical staff said all information for consumers is available in their care plans. Changes or concerns are communicated within the organisation. Care staff said they always check the care plan, progress notes, or handover information to see if there are any new or identified risks such as falls, and if additional assistance to minimise the risk is required.

Hospitality staff said if a consumer’s dietary care plan changes, they are notified by a registered nurse who updates the dietary care plan, and a copy is sent to the kitchen and placed in folders stored in all areas food is prepared or served. The Assessment Team sighted consumer dietary care plan information.

Clinical staff however, advised some consumers had dexterity issues, and they have raised with the kitchen, the provision of specialised cutlery for these consumers. Clinical staff reported they had been advised by kitchen staff that due to limited sets of specialised cutlery, consumers receiving them are prioritised. The Assessment Team noted only standard cutlery was being used in the dining rooms. The Assessment Team raised with management clinical staff concerns, and after investigating, a drawer of specialised cutlery already at the service was presented to management. Management acknowledged a communication issue between the kitchen and clinical staff, and advised an evaluation of consumers dexterity and needs has been identified, and will be undertaken by the care managers. I have considered this information later in this requirement.

The Assessment Team concluded that while the service responded and updated care plans when raised by the Assessment Team, initial consumer care plans sighted were incomplete and did not provide information about the consumer’s condition, needs and preferences.

In its written response the approved provider acknowledged that some improvements could be made based on the findings, and submitted a comprehensive Plan for Continuous Improvement (PCI) setting out the measures it had or was implementing to address the issues identified in relation to care documentation, which appear to have emanated from one particular staff member, who has been cautioned regarding departure from expected standards.

The approved provider stated that, while some information was not complete in care plans reviewed, the key issue was communication within the organisation, and that it could demonstrate there were several avenues in place to facilitate communication within the team for safe delivery of care, and that the care provided was matched to the consumers circumstances, and that in the instances cited this had occurred. It provided this evidence with documentary support:

* in relation to the consumer whose spouse had recently passed away, prior to the site audit they had been referred to their GP following their spouse’s decline, and had been referred to the pastoral manager for emotional support. Their care plan was updated
* in relation to the consumer whose lifestyle and pastoral care plans contained minimal information, and information including ‘about me’ and ‘life history’ was blank, they had also been referred for pastoral support prior to the site audit, and their care plan updated
* in relation to the consumer observed undertaking a particular social activity, with their lifestyle care plan containing minimal information, and not referencing the observed and known social activity, that the care plan in place at the time of the site audit was sufficiently detailed. I have reviewed this care plan and accept this submission
* in relation to specialised cutlery, it denied acknowledging there was a communication issue, noted that specialised cutlery was readily available, and that no need for its use had been identified. The approved provider submitted evidence that an process of communication between the organisation for when residents require specialised cutlery is in place, and provided an example of a consumer who, in November 2024, had been assessed to require thick handled cutlery

In concluding that this requirement is Compliant, I have also considered that the approved provider has demonstrated compliance with all other requirements in relation to this service, which indicates generally robust systems and processes, that it has rectified identified, individual issues, its responsiveness to the issues identified, and that its Plan for Continuous Improvement (PCI) is comprehensive and likely to be put into effect.

I have also considered the Assessment Team’s findings that consumers were being provided with the appropriate care and that staff were well informed and knowledgeable about consumer needs.

# 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

The service is bright and airy, and optimises each consumer’s sense of belonging, independence, interaction and function. Staff throughout the service were welcoming, and all consumers and representatives spoke of how they and their visitors, felt welcomed at the service.

Consumers and representatives all reported the service is welcoming, and optimised their sense of belonging. Examples were provided, such as the placement of Christmas decorations, and that visiting family is made to feel welcome.

Staff spoke about how they provided consumers with a sense of belonging through making them welcome and at home, and this was as simple as offering them a drink on arrival. The Assessment Team observed all representatives interviewed being offered a beverage.

The Assessment Team noted there were small break out lounge rooms with comfortable seating, bookcases, and wall hung pamphlet holders with magazines, puzzle books, newspapers, jigsaw puzzles and games.

The service environment was observed to be generally safe, clean, well maintained, and comfortable. All consumers reported the service was clean and well maintained. Consumers are able to freely access most outdoor areas. Consumers and representatives advised the service is clean and comfortable.

However, on arrival at the service, the Assessment Team observed issues which were reported to management, which management immediately attended to.

Maintenance and management staff advised of other ongoing measures it would undertake to improve cleanliness.

Cleaning staff advised the service undertakes spot checks by the regional manager. The audit involves inspecting 10 rooms, and then an inspection of all areas of the service to ensure windows are clean, and cobwebs removed.

Laundry for personal items is undertaken internally, and external services are used for large items including sheets and towels, and the service is investigating expanding the laundry area to enable all laundry items to be kept internally.

Laundry staff and management advised on entry to the service, consumers and representatives are asked to label items. If consumers are unable to do this, the service provides a labelling service. Laundry staff were observed returning clothing to consumer’s rooms.

On balance I find requirement 5(3)(b) compliant, but encourage the approved provider to ensure cleaning and maintenance improvements are embedded. I note that in Standard 6 I have set out information about the service noticing an increase in trends for complaints around environmental issues related to cleaning, and how they have addressed this.

All consumers and representatives interviewed said they are able to move indoors and outdoors freely. The Assessment Team observed a consumer moving around the service in their wheelchair and sitting in the Sun.

The Assessment Team noted doors leading into courtyards and gardens were unlocked, and main entrance doors and doors connecting internal areas, were automatic opening. A keypad or swipe card access was required to enter or leave the memory support unit. Lawns and gardens were neat and well maintained. Gardening staff also ensure external windows are clean.

The service has effective processes and practices in place to ensure furniture, fittings and equipment are safe, clean, well maintained, and suitable for the consumer. Consumers and representatives did not report any concerns regarding furniture, fittings and equipment, and said when anything breaks, it is fixed promptly.

Cleaning staff advised the scheduled steam cleaning of furniture and carpets is undertaken monthly, and twice monthly if possible. Carpets are also steam cleaned monthly, however will be cleaned if required. Dining rooms are cleaned daily, and chairs with wooden legs are taken outside and cleaned on sunny days.

The Assessment Team noted furnishings were new, light, modern, clean and comfortable. Signs were visible in corridors to assist with wayfinding.

# 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

The service demonstrated all stakeholders were encouraged and supported to provide feedback and make complaints. Consumers interviewed said they felt comfortable and safe providing feedback and making complaints and described the processes in place to enable this to occur. They said management were responsive and proactive in seeking and responding to feedback. Policies and procedures were in place to guide staff in complaints handling and options were available for consumers, staff and representatives to give anonymous feedback.

Management and staff described the escalation processes and systems available for managing verbal or written feedback and complaints. One consumer stated they felt comfortable and supported when giving verbal and written feedback to the service. They said they had a previous complaint in relation to their bathroom not being cleaned on schedule, which was dealt with immediately, and staff now regularly drop by their room to see if they need any support.

Management stated the service had multiple options available for consumers to give feedback. A review of entry packs for consumers showed internal and external feedback options were provided to new consumers and their representatives, including options for anonymous feedback.

Feedback boxes were located throughout the service, and posters and leaflets describing feedback and complaints processes were on display in multiple areas. Consumers interviewed said the manager sought their feedback by regularly walking around the service and asking them if they had any feedback or issues.

Consumers are supported and encouraged to participate in service and organisational meetings. One consumer described their involvement after being approached my management.

The service demonstrated consumers were aware of and had access to advocates, language services and multiple methods for raising and resolving complaints. Consumers described different ways of raising complaints. Staff described ways they support consumers to provide feedback about care and services, including assisting with completing feedback documentation, or using online translation tools. Management said they provided information to consumers on how to raise complaints and access advocacy and translation services, during the entry process and thereafter as required. One consumer described how their specialised needs for assistance were met by use of particular staff as advocates.

Entry packs for new residents, brochures, leaflets and posters on display in various locations at the service included contact details of external advocacy, translation and sensory support services, including the Older Person’s Advocacy Network (OPAN), Seniors Rights Service (SRS), Translating and Interpreting Service (TIS) and the National Relay Service (NRS) Access Hub.

The organisation had also developed an internal brochure on feedback and complaints mechanisms, which included all relevant contact details and was on display throughout the service.

The service demonstrated appropriate action was taken in response to complaints and open disclosure was used. Consumers said feedback and complaints were promptly responded to, open disclosure was practiced when needed, and they were satisfied with the outcomes of complaints. The organisation had systems, policies and education in place to guide staff on complaints handling and open disclosure, including when adverse events occurred. Roles and responsibilities were clearly defined in policy and processes for responding to complaints. Staff interviewed described feedback mechanisms available and processes in place for reporting and escalating feedback and complaints. Complaints were resolved quickly, with management involvement and oversight of most feedback. Documentation review showed feedback was being regularly captured and recorded and linkages to continuous improvements were observed.

Management demonstrated complaints and incidents were entered into a register and automatically escalated to management to oversee and resolve. A new risk escalation matrix guided staff on who to escalate complaints and incidents to and when to practice open disclosure. Complaints were tracked and appeared on management reports and dashboards to alert management to progress. Apologies and open disclosure were practiced where appropriate, most often in a verbal way, and documented in the complaints register or consumer care planning documentation.

Staff interviewed said they would advise management if an adverse event occurred. One registered nurse said if mistakes or errors occurred, they always felt supported by the manager and workplace educator. Another staff member said they would always tell management if something went wrong because ‘you have to have integrity’. Staff interviewed were aware of open disclosure, said they received education on this topic during orientation, and knew about the new risk escalation matrix and reporting processes in place.

The service demonstrated it reviewed feedback and complaints and used this information to improve care and services. Consumers and staff interviewed gave examples of continuous improvements made after providing feedback or making complaints. Management demonstrated improvements in the systems used by the organisation to collect, monitor, review and finalise complaints.

Complaints and feedback were reviewed by multiple levels within the service and organisation to monitor for trends, risks and opportunities for improvements.

Management said they had noticed in increase in trends for complaints around environmental issues related to cleaning. In response to this, the responsibility for cleaning moved internally, where staff education and monitoring of performance could be closely managed by the service. A cleaning and laundry manager role was recruited for the service and regular cleaning audits setup in the audit schedule. A specialised cleaning staff training program was developed by the workplace educator and documentation review showed relevant staff were provided with training, with the most recent date of training being the 22 November 2024.

Feedback and complaints from consumers through ‘resident and authorised representative meetings’ or one on one meetings with the manager resulted in improvements, including equipment being provided to allow consumers to do their own personal laundry if they preferred this, and new armchairs purchased for a small sitting room area to provide a private nook for consumers to sit in.

In the last year, the service had introduced a new complaints and incident management system, and staff were provided with education and process guides to assist them in the data entry and risk escalation process.

# Standard 7

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

Findings

The service demonstrated it had systems, policies and processes in place to ensure the workforce was planned to enable the delivery of safe and quality care and services. Regional business partner roles supported the service with recruitment, human resources and operations functions. An administration manager controlled the rostering process for the service, with planned and unplanned leave well managed, and surge workforce options available through casual staff and agency support when needed.

Consumers and representatives interviewed provided positive feedback about the standard and quality of the care and services they received, and consumers felt safe during care delivery. For example, seven consumers interviewed said they felt safe during care delivery, did not have to wait long for staff when using their call bells, and staff always assisted them quickly.

Management stated they reviewed call bell reports daily and investigated anything over 10 minutes duration with the care managers. Documentation indicated response times were reviewed, with investigations occurring if required. Average response times appeared appropriate.

Staff interviewed said they generally had enough time to complete tasks and felt supported by management. Two staff members said it would be good to

have an extra person in the mornings, however, were unable to describe any current impact on consumer care. Management said they would review this suggestion with staff.

One consumer stated mealtimes could be busy, but since the service had merged 2 of the dining spaces into one, there were more staff available to assist consumers.

Management outlined measures in place to increase permanent recruitment, and strengthen the internal casual pool. Management stated consumer satisfaction with staffing had increased and this was reflected in consumer interviews during the Site Audit. Documentation review showed measurable improvements in relation to the improvements implemented.

The service demonstrated workforce interactions with consumers were kind, caring and respectful of consumers’ identities, culture and diversity. Consumers and representatives interviewed said staff were kind, caring and respectful when delivering care and services, and feedback about staff was positive. They stated their individual needs, identity, culture and diversity was recognised and supported. Staff interviewed were knowledgeable about the consumers they cared for. Management expectations of staff around respect, diversity and code of conduct were clearly articulated in policies, staff manuals, orientation and annual training.

Under Standard 3 I have summarised the compassionate and appropriate management of the emotional and physical aspects of a consumer’s passing, with their surviving spouse articulating the empathetic and informed support given to them and their spouse.

Consumer expressed how staff could have a joke with, treat them the way they like to be treated and knew them well. Staff interviewed knew what to do if they witnessed another staff member being disrespectful, talked about the escalation processes in place, and confirmed they received initial and ongoing education around culture, diversity and respect.

The workplace educator said the organisation had developed education for staff who were potential buddies for new starters, called ‘developing buddy skills‘. After completion of this training, these staff members were used as buddies for students or new starters and embodied the expectations and standards of care expected by the organisation. Documentation review showed some staff had completed the training with further staff identified for training in 2025. One staff member interviewed confirmed they had been trained as a buddy and helped train staff in the standards of care expected by the service.

The service had policies in place around cultural safety, diversity and inclusion. Documentation review showed the service’s mission, vision and values and a focus on cultural safety, diversity and customer service were embedded in job descriptions, training, and employee orientation guides.

The service demonstrated the workforce was competent and had the qualifications and knowledge to effectively perform their roles. Regional recruitment partners and an on-site education program supported management in assessing and monitoring skills and competencies, and ensuring knowledge was maintained appropriate to the roles being performed by staff. Rostering processes matched staff competency and qualifications to rostered services, ensuring staff were working within their designated scope of practice.

Consumers interviewed said they felt staff had the skills to perform their roles.  Staff interviewed understood their scope of practice and could describe the competencies required to provide certain services to consumers. One care worker explained they were a ‘medication marshal’ and workplace buddy. They said they had undergone competency training for these roles.

Management said staff skills were assessed prior to employment and staff allocated to shifts in the rostering system according to their qualifications, knowledge and competency levels. Vacant shifts were automatically offered from the rostering system to anyone qualified for that role. A second manual check by the administration manager then selected the most suitable staff member to perform the role. The service’s rostering system prevented staff being rostered to shifts if key competency or qualification requirements were not met or out of date.

Documentation review of unfilled shifts for the last fortnight showed vacant shifts were appropriately filled by suitably qualified and competent staff.

The service had 2 current infection prevention and control (IPC) leads who had received the required training to perform the role. The workplace educator said all staff receive annual IPC competency training and this was demonstrated in the education matrix and education completion rates report for staff. A registered nurse said during a recent COVID-19 outbreak, additional IPC education was provided, and spot checks carried out on PPE use and IPC processes.

The service demonstrated the workforce was recruited, trained and equipped to deliver outcomes under the Quality Standards. Regional operational and recruitment business partners supported the service in ensuring compliance with employment requirements. Service based education staff provided initial and ongoing training programs to ensure standards of care were maintained.

Staff said they felt supported and trained to deliver the outcomes required under the Quality Standards. Consumers interviewed said staff were well trained.

Documentation review and interviews with management and the workplace educator showed a comprehensive education program was established at the service. This included an induction and orientation program for new starters and agency staff, a workplace buddy system incorporating trained workplace buddies, and an education matrix covering training and competency requirements for all roles within the service.

Proactive and reactive education was conducted in response to trends, performance issues or analysis of care and services. Staff interviewed said they had participated in an induction program including buddy shifts and received regular ongoing education. One registered nurse said they had returned recently from long term leave and found a new rostering system and feedback and incident management system had been implemented. The service ensured they were buddied up with other staff on their first day back at work and the workplace educator provided additional training.

Recruitment processes at the service were overseen by a regional recruitment business partner and compliance was monitored within a new information system, implemented in early 2024. Documentation review for sampled staff showed workforce recruitment and compliance documentation was up to date and matched policy requirements.

The service demonstrated regular assessment, monitoring and review of the workforce was occurring. Consumers interviewed said feedback about staff performance resulted in improvements or changes being made. Documentation review showed regular assessment and performance monitoring was taking place. Staff interviewed stated they received regular assessment of their performance and felt supported by management. Staff interviewed said they had received their performance assessment for the current year. Staff described the new process, including an online self-assessment tool. All staff said they were comfortable talking with management and felt supported in their roles. Some staff had requested additional training in their performance assessment, and one registered nurse said management was always asking them in staff meetings if they needed any extra training or equipment.

 An interview with the workplace educator and documentation review demonstrated the service was proactively and reactively improving staff performance, in response to performance issues or using data analysis, and identifying opportunities for education. For example, in relation to trend analysis in the prescribing of antibiotics, which resulted in improvements, and review of documentation and investigation of incidents.

# 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**

The organisation demonstrated an inclusive approach to engaging consumers in the development, delivery and evaluation of care and services. Documentation review and governing body interviews demonstrated a comprehensive governance framework was in place and had been developed to support and encourage inclusion and engagement of consumers at all levels of service delivery. Consumer representation was established within the organisation, and consumers described ways they took part in the development, delivery and evaluation of care.

Documentation review of the consumer admission pack and the organisation’s 2024 annual review identified multiple opportunities for consumers to be involved in the development and evaluation of care and services. The organisation had programs in place to encourage and include consumer participation. For example, consumer and authorised representative meetings were established, with review of minutes showing a two-way flow of information between the governing body and consumers, including information on trends, analysis, changes in legislation, continuous improvement initiatives, and care and services. Consumers were encouraged to lead and facilitate these meetings.

The organisation demonstrated it had established a Consumer Advisory Body (CAB) and a Quality of Care Advisory Body (QCAB), with consumer representation. Documentation review showed these committees were involved in the monitoring and development of care and services, for example, the review of a new organisational feedback and complaints brochure for consumers in early 2024, observed to be on display and in use at the service.

Minutes of board meetings showed the governing body received and responded to feedback and input from consumers in multiple ways. This included through board sub-committees including the quality and safety committee, management reports, complaints and feedback summaries, consumer survey results and recommendations, and areas identified for improvement.

The organisation’s governing body demonstrated it promoted a safe and inclusive culture, with accountability for delivery of care and services clearly defined. Escalation protocols for feedback, complaints, risks and incidents were in place, ensuring the governing body received the information required to meet its responsibilities. A continuous improvement culture was established within the organisation and documentation review showed evidence of information flowing to and from the governing body. For example, the governing body had a site visit plan in place. This ensured the board were visible at the service level, maintained oversight of services, and were accessible to consumers and staff. Evidence showed the service was visited on the 17 July 2024 by the board.

Consumers said they felt safe during service delivery and said the organisation actively sought their feedback into improving care and services.

Staff described a safe working culture with support available from managers and other staff when needed. Formal proactive and reactive training programs were in place and staff stated they had been trained in risk identification, incident escalation procedures, Serious Incident Response Scheme (SIRS) and infection prevention and control. They were aware of a new organisational risk escalation matrix in place, guiding staff on who to contact, when to escalate, and who was responsible for managing feedback, complaints and incidents within the organisation.

Documentation review of the quality and safety board sub-committee and related reports showed the governing body was actively promoting a safe and inclusive culture. Through this sub-committee, the board received information on multiple areas of care and services, such as trend analysis, clinical incidents, outbreaks and infection, continuous improvements across the whole organisation, and recent review of organisational emergency management plans.

The organisation demonstrated organisation wide governance systems were in place and used effectively to improve outcomes for consumers. The systems of care and services in place were monitored and evaluated to ensure they were safe and effective. Consumers said the organisation was well run, they were involved in giving feedback in multiple ways and saw improvements to care and services as a result. Operational policies and procedures were in place, reflected best practice, and provided for staff as a guide for standardised expectations of care and services across the organisation. Responsibilities and accountabilities were defined and documented, and staff understood levels of responsibility within the organisation.

The organisation’s information management systems included a policy and procedure framework accessible by all staff via the intranet, through laptops and computers located within the service environment. The framework was developed by the governing body through the policy board sub-committee and reviewed at the board level. Processes were in place to ensure currency and inclusion of best practice guidance through a review cycle, and staff interviewed said they had access to the information they needed to help them in their roles. Additionally, the service demonstrated responsiveness to trends and staff needs by developing information at the service level to support staff.

Information systems were in place to assist the governing body in managing and providing safe care and services. Board committee and meeting records demonstrated the governing body had the information required to make informed decisions

Consumers and representatives said they had access to the information they needed to enable them to make informed decisions about their care and services. This included on entry and throughout their time with the organisation,

through posters, newsletters, and meetings.

The governing body demonstrated a strategic focus on improving electronic information systems over the last year. In the last 12 months, a new rostering system, human resource system and feedback and risk management system have been implemented throughout the organisation, automating many of the escalation processes and compliance requirements for the organisation.

Systems used were password protected and accessible only by staff with the relevant authority to access the information. Consumers and representatives were satisfied their information was kept confidential and secure.

The organisation had a PCI in place and policies to guide staff in the use, evaluation and monitoring of improvements. Documentation reviewed showed the governing body received copies of the plan for discussion at board and board sub-committee meetings.

Consumers and staff said they were involved in the review of information on the safety and quality of care and services, and able to recommend or influence change.

The organisation demonstrated processes were in place to provide governing body oversight of the financial systems and financial position of the organisation. Budgets were monitored monthly by the governing body for all services and analysis of financial position undertaken. Regional manager oversight provided support to managers. An approvals process was in place with regional managers for any items outside of the approved budget and evidence showed the governing body was responsive to requests from the service to increase the budget in response to changing or increased consumer needs. For example, management provided evidence of minutes of resident and authorised representative meetings, showing requests from consumers for more lifestyle activities on weekends and access to bus services throughout the weekdays. This was seen to be approved.

The governing body demonstrated it had workforce governance practices in place to minimise risk to consumers and ensure a consistent organisational approach to the delivery of care and services. The organisation had regional human resource, operational, and recruitment roles in place to support services in ensuring compliance with regulatory workforce requirements. New information systems were in place to provide monitoring of compliance and to automate the internal processes around workforce management.

The Assessment Team reviewed the organisational policies and procedures, and these provided guidance for members of the workforce across all Requirements within the Quality Standards. Workforce roles and responsibilities were clearly outlined in job descriptions, policies and procedures, the risk escalation matrix, and induction processes.

Where services were not provided internally, appropriate contracts were in place to manage expectations and guide external workforce providers, for example, for agency contract staff. Organisational surge workforce contracts were in place using a third-party employment agency portal.

Recruitment compliance was monitored by regional support roles, and these worked closely with the operational manager on site. Human resources support roles assisted management with performance management and industrial relations compliance related to the workforce. The organisation demonstrated a thorough induction and orientation program was in place, with ongoing mandatory, proactive and reactive training occurring. Two trained IPC leads were available at the service and were supported by the governing body through an organisational IPC clinical lead. Staff interviewed said they trusted the organisation and would come forward if an adverse event occurred.

Feedback from consumers and staff, and management review of the workforce, resulted in recent improvements in care and services.

Regulatory compliance within the organisation was monitored by the legal department of the governing body. The legal team was responsible for submitting a legislative update report to the board and relevant board subcommittees.

Compliance requirements were monitored by the governing body through memberships with key industry bodies, email alerts from government agencies, news, bulletins and awareness of legislative changes. The organisation demonstrated compliance was monitored through multiple sub-committees feeding into the board, including a finance risk and audit committee, a people and remuneration committee, and the quality and safety committee. Recommendations for changes flowed up to the governing body, and changes filtered down to the service level as required. This included changes to policy, processes, education and existing frameworks. The governing body demonstrated a good understanding of legislative requirements during interviews with the Assessment Team, and responsibility for monitoring and updating the governing body regarding regulatory compliance was clearly defined in the policy framework.

The organisation demonstrated compliance with recent changes to governing body requirements detailed in the Aged Care Act 1997 and the Aged Care Quality and Safety Commission Act 2018. Evidence was reviewed showing education around these changes was provided to board members and a board members skills matrix and training and development register was in place.

The governing body demonstrated a proactive and engaged approach to their obligations around regulatory compliance, for example, the governing body demonstrated an email trail showing they had begun exploring options for identifying affected staff using their information systems, following the Commission advising of the deregistration of a Vocational Education and Training Provider.

Consumers, representatives and staff stated they were comfortable providing feedback and making complaints and were aware of the systems in place to enable this. Consumers and staff described the ways information flows to and from the governing body, including through newsletters from management, information provided at meetings, and alerts on the intranet for staff.

The governing body received trend data and analysis of complaints and feedback at the quality and safety board sub-committee and board meetings. Interviews with the governing body and review of documentation from meeting minutes showed feedback was informing continuous improvement at an organisational and service level, and actions were listed in both the service and organisation level plans for continuous improvement, related to consumer feedback.

The organisation demonstrated risk management systems in place were currently effective in managing risks. Policies and procedures existed to guide staff in processes at an operational level and regional support roles worked with the governing body and the service to identify and assess risks, apply interventions, and monitor their effectiveness. An electronic care management system (ECMS) was in place for staff to access best practice guidance and assessment tools to assist in identifying and managing consumer high impact high prevalence risks. An incident management system was used to document incidents, escalate to the governing body where appropriate, and drive and influence continuous improvement. The organisation trained all staff in safeguarding and incident management processes, and audits and trend analysis were influencing workforce education.

The governing body demonstrated high-impact high-prevalence risks were managed through a layered approach involving staff, consumers and the governing body. high-impact high-prevalence risks were identified by the organisation through the use of clinical risk indicator reports, which identified risks and rated them for each consumer using a new enterprise risk incident escalation matrix. Clinical audits and analysis of trends were also used to identify the high-impact high-prevalence risks for the service and rate the service within the organisation across various risk indicators.

The governing body stated the current high-impact high-prevalence risks for the service were falls, wounds and staff turnover, and these were identified through trend analysis reviews at the service level, at board governance sub-committees and board meetings.

The governing body stated an organisation wide falls prevention program had been implemented across all services in 2024 following a deep dive analysis of falls data. Documentation review of minutes of meetings and PCI reports showed additional deep dive analyses requested by the governing body to manage high-impact high-prevalence risks to consumers included analysis and reviews of nutrition and hydration, end of life care and palliative care, and medication management.

Nutrition and weight loss were identified by the governing body through analysis and trending as high-impact high-prevalence for the organisation in early 2024. A deep dive analysis was requested from the quality and safety committee in March 2024, to understand the key drivers of weight loss. A documentation review of the service level education program showed staff were given education around a new policy arising out of this, and ongoing auditing was occurring to monitor compliance. Additional education on high-impact high-prevalence risk identification and management took place at the service in late 2024.

The organisation demonstrated it was identifying and responding to abuse and neglect, including the requirement to report relevant incidents to the SIRS. The governing body understood the requirement to report actual or alleged abuse and neglect under the scheme, and all staff had received education on SIRS and incident management. Staff interviewed described different types of abuse and neglect and their obligations to escalate to management. Service level reports under the SIRS were automatically escalated through the organisation’s incident management system to the governing body, who reviewed SIRS reports at board and board sub-committees. The risk rating applied to incidents of abuse and neglect determined the level of escalation within the management framework at the organisation. The governing body demonstrated a layered approach to monitoring actual reported or possible SIRS.

The organisation demonstrated it supported consumers to live their best life, through a collaborative and inclusive approach to the delivery of care and services. Services were implemented by the organisation to support consumer quality of life in line with their assessed needs and preferences, with external supports accessed where required. Risk management processes ensured consumer choices were managed and supported within the organisation by the governing body. Programs were in place to include and engage consumers in improving the quality and management of care and services and enable them to live their best lives.

Consumers interviewed felt supported and heard by the organisation, felt they had a voice and said they were happy living in the service.

The organisation demonstrated an incident management system (IMS) was in place to record, assess and document interventions in relation to incidents. External bodies were notified of relevant incidents, and internal reporting frameworks ensured incidents were escalated automatically to the governing body as appropriate. Policy guidance, manuals, and an enterprise-wide risk escalation matrix were in place for staff and information provided to staff at induction, to underline the importance of incident management. Ongoing education for staff in infection prevention and control, SIRS, safeguarding, incident management and clinical risks, ensured a culture of staff awareness.

Staff interviewed understood their obligations to report and escalate incidents and said they had received initial and ongoing education.

The governing body received detailed analysis and reports on trends and interventions in relation to incidents and SIRS, and the organisation’s PCI and education calendar showed incidents were informing continuous improvement, often driven by the governing body, such as a recent review of the organisation’s emergency management plans.

The governing body provided proactive updates to services around common risks and potential incidents, including clinical email alerts for hot weather and summer months. Documentation review showed email alerts were received regularly by the service, including on 11 December 2024. The workplace educator demonstrated evidence of education slides and handouts for staff had been developed, and training delivered in-house on in late 2024.

The organisation demonstrated the governing body had quality and safety systems in place to enable oversight of clinical care. A clinical governance framework was in place with defined roles and responsibilities for clinical care across the organisation. This included policies, standardised procedures and best practice guidance for staff on management of anti-microbial stewardship, restrictive practices and open disclosure. Clinical risk assessment was occurring for consumers and effective organisation wide systems for preventing, managing and controlling infections were in place.

The governing body had multiple layers of oversight built into their clinical governance framework and these were effective at recognising and responding to clinical risks, with evidence of continuous improvement responses occurring. Whilst the service demonstrated most consumers documentation around assessment and planning was current, the Assessment Team reported that this was not demonstrated for some consumers. Management responded immediately with a plan for continuous improvement.

In relation to these matters, while I have identified areas for improvement in relation to requirements 2(3(b) and 4(3)(d), I have found the approved provider compliant with these requirements.

The organisation had a policy in place for Antimicrobial stewardship (AMS), a centralised governing body medication advisory committee (MAC), a service level MAC, and reporting structures in place to ensure information filtered both ways within the organisation. Service level reports were received from the pharmacy and the electronic medication system, and these were discussed at the MAC meetings, with AMS being a standing agenda item on all MAC meetings. The governing body received reports directly from the MAC meetings with recommendations for changes or improvements. Staff interviewed were knowledgeable about AMS and stated they had received education on this topic. A review of the staff orientation pack for new starters showed AMS was included in initial information for staff. A review of documentation for the organisation showed a proactive approach from the governing body and service in managing AMS awareness and practices.

The organisation had a positive behaviour support and restrictive practice policy in place to provide guidance to staff and management on the use and minimisation of restrictive practices. Staff interviewed stated they had received education on restrictive practices and education documentation reviewed showed this was part of the mandatory training program. The governing body received reports on quality indicators from all services, including details of restrictive practices and antipsychotic medication use. Use of chemical restrictive practices was further monitored by the governing body through their organisational MAC meeting.

The governing body demonstrated evidence they had received a recent review into restrictive practices by the organisational legal team. This prompted them to request a deep dive analysis into all restrictive practices in use across their services, and this report was due to be presented to the governing body in February 2025.

The organisation had an open disclosure policy and procedure to guide services in principles and key elements of open disclosure practice. The policy contained step by step process flowchart for management and staff to follow, with clear delegations of responsibilities outlined for both staff and the governing body. A new risk escalation matrix was introduced in 2024 to further guide staff in process and responsibilities and this was observed displayed on walls in key office areas, with staff pointing this out during interviews. A review of the staff orientation pack for new starters showed open disclosure was included in initial information given to staff. A new incident and feedback and complaints management system required management and staff to provide details of open disclosure, if practiced, and this was monitored at a regional level by the organisation.

The consumer admission pack and resident handbook explained open disclosure to consumers upon admission. Management and staff interviewed at the service demonstrated an awareness of open disclosure and when to apply this in practice, and documented evidence was reviewed confirming the practice was occurring in relation to feedback and complaints and adverse events.

Consumers and representatives sampled said they received apologies from the service when issues occurred.

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)