Performance

Report

**1800 951 822**

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| Name of service: | Heritage Botany |
| Service address: | 31 Edgehill Avenue BOTANY NSW 2019 |
| Commission ID: | 0519 |
| Approved provider: | Heritage Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 30 May 2023 to 1 June 2023 |
| Performance report date: | 06 July 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Heritage Botany (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment conducted on 30 May 2023 to 1 June 2023, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Team’s report received 19 June 2023, advising they have accepted the report and will not be providing a further response.
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service – Notice of Non-compliance dated 10 June 2022 following Site Audit conducted 29 March 2022 to 4 April 2022; Performance Report dated 20 May 2022 for Site Audit conducted 29 March 2022 to 4 April 2022.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

**Areas for improvement**

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)(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**

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Three of the six specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022 the service was unable to demonstrate all consumers were consistently treated with dignity and respect. Deficiencies were identified in consumers and representatives receiving accurate information that would assist consumers, including those from a non-speaking English background to make day-to-day decisions about their care and services. Staff indicated they were aware of interpreting services, however most indicated that they do not use them to communicate with consumers. The Assessment Team also found that the service was unable to demonstrate that consumers’ privacy and confidentiality was always protected when attending to personal care in shared rooms and keeping documentation private.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit including toolbox education for all staff relating to privacy and dignity, attending to call bells, meals assistance and interacting with consumers from non-English speaking backgrounds and on how to use translator applications. The service has encouraged feedback/suggestions from consumers and representatives in regard to dignity and respect during consumer/representative meetings. Lifestyle staff are present to assist during mealtimes in dining rooms and registered staff supervision during mealtimes is in place to ensure engagement. Management reviewed care plans together with consumers and or their representatives on their behalf and offered copies of their care plans in their language if required with lifestyle staff assessing consumers languages spoken to ensure consumers care plans are current. In order to maintain consumers privacy, an automatic log off timer was actioned for all computers after inactivity for more than 5 minutes and the nursing station doors had door closers fitted.

During the Assessment Contact conducted between 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. The service demonstrated and consumers and representatives confirmed consumers are consistently treated with dignity and respect with their culture and diversity valued. Sampled consumers care plans reflect the diversity of consumers, including information about their cultural and religious beliefs and preferences. Staff were observed interacting with consumers respectfully and were familiar with consumer’s backgrounds. The service has policies that outline what it means to treat consumers with dignity and respect.

The service demonstrated that there are processes to ensure information is provided to consumers and representatives including those from a non-English speaking background in a timely manner. Consumers and representatives interviewed indicated there has been significant improvements in the way they receive information such as written, and verbal communication which is language appropriate. Staff interviewed demonstrated ways in which they communicate with consumers, including those from a non-English speaking background and those living with dementia. Documentation reviewed indicated that information provided to consumers is current, clear, and easy to understand.

The Assessment Team observed the service uses cue cards to communicate with consumers who have reverted back to non-English speaking, and meeting minutes, menus, lifestyle calendars and other communications translated in languages of the consumer cohort.

The service demonstrated that there were processes to ensure consumers privacy is respected and their information is kept confidential. Consumers and representative interviewed indicated staff maintain their privacy and dignity in personal care and staff keep their information secure. Staff interviewed demonstrated a sound knowledge of the importance for maintaining their confidentiality and their privacy is respected in all aspects of care. Devices are locked down and nurses locked when not in use as part of maintaining confidentiality of the consumers information.

The Assessment Team observed the delivery of care was respectful and ensured consumers privacy was maintained. Staff were observed knocking on doors and gaining permission before entry.

The Assessment Team found that staff received education on ensuring consumers receive privacy at all times including during provision of personal care. They also received education on the importance of ensuring consumer personal information is kept confidential.

**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)(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**

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Five of the seven specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022, the service was unable to demonstrate consumers get safe and effective personal care or clinical care that is tailored to their needs and preferences or is best practice. This was related to behaviour management, pressure injuries, diabetes and wound management where wounds were not being reviewed regularly. The service also did not demonstrate they followed organisational post falls policy in relation to neurological observations. Consumers provided negative feedback about how the service was managing their risks. The service was unable to demonstrate that sharing of consumer information has always occurred and information in consumer care and service records and reports was incorrect or inconsistent. The service was unable to demonstrate appropriate referrals to relevant health professionals were always undertaken or were undertaken in a timely manner. Care planning documents did not evidence the input of doctors and allied health providers and referrals where needed. Issues were also identified in relation to COVID-19 preparedness and prevention, staff practices in relation to hand hygiene were not observed to be in line with protocols or best practice and shared equipment was not being cleaned between consumer use appropriately.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit with a range of education and Toolbox talks provided to staff, the service received advice from Dementia Services Australia for a deterrent for wandering consumers, consumers had their behaviour support plans reviewed with staff that are familiar to the consumers. Falls strategies have been reviewed and are to the maximum benefit to prevent injury. The DON meets with all registered nurses daily as part of clinical catch-up. This includes the review of items and consumer issues that occurred in the last 24 hours and the plan for the next 24 hours and all team members are required to be available for handover.

During the Assessment Contact conducted 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. The service demonstrated that there are processes to ensure each consumer receives effective personal and clinical care. All consumers and representatives interviewed indicated they were satisfied with the care they received, and consumers and representatives indicated that the care has improved significantly under the new management team. All staff interviewed demonstrated a sound knowledge of individual consumer care needs. Staff indicated things have improved for consumers since the new managers commenced at the service. Documentation reviewed indicated that the director of nursing (DON) has effective clinical oversight of consumer care and that the registered nurses are implementing care that is tailored to consumer needs.

The Assessment Team identified that the service demonstrated that there were processes to ensure the effective management of high prevalence high impact risks. Consumers and representatives indicated satisfaction with the management of consumers falls. The registered nurses indicated that there is a comprehensive review of consumers who are a high fall risk or have risk of head injury following a fall. Documentation reviewed indicated that the registered nurses and the DON comprehensively review consumers incidents to identify risks and implement strategies to mitigate consumer risks.

The service demonstrated that there were processes to ensure that the sharing of consumer information occurs with providers of care within the service and with others where responsibility of care is shared. The service has implemented a new electronic care planning program that facilitates the identification of consumers conditions, needs, goals and preferences. Consumers and representatives interviewed indicated satisfaction with the communication of the consumers care information. Staff indicated there was an effective handover process that ensures they have current information regarding consumer care needs.

The service demonstrated that there were processes to ensure timely and appropriate referrals to allied and other health specialists and to the consumers medical officers in response to consumer needs. Consumers and representatives indicated they were satisfied consumers were seen by their medical officer or other appropriate providers of care and services. Staff interviewed demonstrated a sound knowledge of consumers care following referral and review by other providers of care and the consumers’ medical officer. Documentation reviewed indicated consumers are referred to specialists and other health provider in response to their assessed need and the referrals occur in a timely manner.

The Assessment Team also found that the service demonstrated that the infection control system and process in place minimises the spread of infection. The DON and registered staff demonstrate an understanding of antimicrobial stewardship and the principles for outbreaks as well as standard precautions. The service had an outbreak preparedness plan and associated documents in place to guide their practice in the event of an outbreak. There is an IPC lead for the service. The service has a surveillance system in place to record when infection incidents occur. The DON indicated the staff request the medical officer to order pathology prior to commencing antibiotics. Staff were observed wearing face masks and washing and sanitising hands throughout the site audit. Consumer care planning documentation for consumers sampled indicated when consumer infections have occurred and or preventative measures to mitigate risk of reoccurrence of a repeat infection.

**Standard 4**

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| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |

**Findings**

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of the seven specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022 feedback from consumers indicated they were feeling unsupported in terms of emotional wellbeing and there were inconsistencies in their care plans in relation to spiritual needs and emotional support.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit with the service coordinating an external service to provide education to the staff in relation to emotional well-being and what it means. Consumers are provided with referrals and assistance to access other services such as emotional wellbeing for older persons (EWOP) or older persons advocacy network (OPAN) and care plans have emotional strategies in place.

During the Assessment Contact conducted 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. The service demonstrated there were services and supports available to promote consumers emotional, spiritual and psychological wellbeing. Consumers interviewed indicated they are supported by staff and external providers when emotionally down. The service provides spiritual support which includes the Catholic Church, Greek Orthodox Church, and Jewish Church. Documentation reviewed indicated that consumer spiritual, emotional and psychological needs are identified and reflected in consumer care plans. Staff demonstrated individual knowledge of consumers spiritual needs and in what circumstances the consumers need emotional support.

**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 |

**Findings**

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of the three specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022 the service was unable to demonstrate the environment was welcoming and optimised each consumer’s sense of belonging, independence, interaction and function. The service environment did not enable consumers living with dementia to optimise their interactions and functions. The service environment had limited indoor and outdoor areas for consumers interaction and function. Consumer rooms were observed not to be personalised or welcoming.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit with all items blocking doorways such as emergency exits and toilets removed with reminders sent to all staff. Toolbox talks were provided to staff on clearing clutter within the home including, skips, trolleys, and chairs in corridors and garden exit doors remain unlocked to facilitate free access for consumers. An external electric wall heater was purchased and hung to keep the environment warm. The heaters are on a timer for safety, so they are not left on 24/7. Garden area tables are set up in a way that does not impede consumer movement. The service has seating outside for consumer to have meals during lunch weather permitting.

During the Assessment Contact conducted 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. Consumers and representatives interviewed confirmed the service environment is welcoming for them and they said they feel comfortable at the service. Consumers were observed moving around the service using a range of mobility assistive equipment, including wheelchairs and 4 wheeled walkers. The Assessment Team observed some wayfinding signs to assist consumers find their way to their rooms and communal areas. The Assessment Team also observed that some consumers had personalised their rooms however management advised that consumers and representatives have the right to personalise or not personalise their room and the choice was the consumers. Consumers interviewed indicated they were satisfied with their rooms the way they are. The service has reviewed the downstairs courtyard and have created a sensory garden with raised garden beds and a walking pathway. Consumers and representatives provided positive feedback in relation to the garden. The service acknowledges it is an older building and they are working towards improving the environment within the confines of the building structure. The organisation indicated they have a PCI to replace the flooring and paint inside the building in the 2023/2024 capital budget.

**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)(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 Quality Standard was not fully assessed, and therefore has not received a compliance rating. Three of the four specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022 the service was unable to demonstrate consumers and representatives are encouraged and supported to provide feedback and make complaints or that timely or effective action is taken in response to complaints or that feedback and complaints were used to improve the quality of consumers’ care and service. Some representatives indicated they did not feel confident that there would not be negative consequences for the consumer if they raise a concern or complaint. Consumer and representative feedback indicated the service did not demonstrate that there is an open disclosure practice. Consumers and representatives also indicated they were increasingly frustrated that the service took a long time and sometimes did not get back to them with follow-up information. The service did not demonstrate that they are trending and analysing complaints to improve care and services and to inform continuous improvement. Repeated complaints that were impacting the comfort and dignity of consumers were found. Although these had been addressed it took several complaints to initiate preventative, effective improvements. Staff interviewed were not able to describe the service’s open disclosure flow chart nor were they able to describe the service’s complaint and feedback policy and how the policy was used in relation to complaints. The complaints register contained numerous complaints which were not closed in a timely manner and the service’s response did not follow the organisation’s open disclosure process.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit with the service sending emails to all families encouraging feedback and complaints. Posters have been placed around the facility that encourages feedback and complaints and the service has committed to ensuring all feedback received is provided with acknowledgment receipt and a realistic follow-up period. The service has provided toolbox education to all staff regarding open disclosure and escalation of complaints and spot checks are being completed by the organisation’s visiting team on what is open disclosure.

During the Assessment Contact conducted 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. The service demonstrated that there were processes to ensure consumers and representatives were supported to provide feedback and make complaints. Consumers and representatives interviewed indicated they are comfortable providing feedback and complaints at the service and said staff listen to them when they have a complaint. The service provided examples of how consumers and their representatives are encouraged to give feedback with complaints forms and Aged Care Quality and Safety Commission feedback brochures, 'Have you got a concern' available for all consumers and representatives. The resident and representative forum meeting offers consumers and representatives an opportunity to provide feedback. This meeting is open to representatives to attend remotely if not able to attend at the service. The service manager has an open-door policy for families to come and offer suggestions, raise their concerns or make a complaint. Consumers and representatives interviewed indicated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. All feedback received showed the current management team are supportive of receiving feedback.

The Assessment Team found that the service demonstrated that there were processes to ensure feedback and complaints are reviewed and used to improve the quality of care and services. Consumers and representatives expressed satisfaction in the way the new management team are using complaints and feedback to improve services for consumers. The service provided an example to the Assessment Team where the service received complaints from consumers regarding lack of available footpath to safely manoeuvre their wheelchairs and 4 wheeled walkers in the courtyard. In response the service liaised with the consumers and constructed pathways that facilitated consumer access. Consumer feedback received by the Assessment Team was positive in relation to this initiative.

**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 Quality Standard has been assessed as compliant as five of the five specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022 the service was unable to demonstrate there was sufficient staff and timely call bell response times. Consumer and representative feedback at the time identified that not all workforce interactions were respectful and caring or that the workforce was competent and had the knowledge or training to support them to effectively perform their roles. The service was unable to demonstrate its workforce was recruited, trained, equipped and supported to deliver the outcomes required by these standards or that staff performance issues are identified and that they were consistently addressed by management.

The Assessment Team had found during that Site Audit most consumers and representatives interviewed were not satisfied with the staff sufficiency, communication, language barriers and call bell responses. They indicated staff are rushed, busy, stressed and unable to always meet care needs and this impacted consumers health, wellbeing and dignity when staff assistance is not available when needed for personal and continence care. Consumers indicated there was a high reliance on agency staff who do not know the consumers well. Consumers and representatives interviewed indicated they were not always confident that staff are skilled and competent to adequately meet their care needs. They provided examples where personal and clinical care was not delivered in-line with their individual needs. These were also directly observed by the Assessment Team during the Site Audit. There was no evidence of evaluation of the agency staff orientation checklist to show staff understood the content. Management could not provide evidence of how consumer feedback was incorporated into staff performance reviews.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit with ongoing training and education, ongoing recruitment in place and consultation with agencies to identify the agency orientation conducted. The service is using consumer feedback to review staff behaviours and performance and feedback gathered from consumer and representative meetings, the importance of kindness in the consumers’ home is reiterated to all staff. The service has conducted a review of performance appraisals for all staff and scheduled those that have not been completed and promoted to all staff that English is the only spoken language within the home, with spot checks occurring.

During the Assessment Contact conducted 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. The service demonstrated that there were processes to ensure the workforce is planned to meet the needs of the consumers and provide safe and quality care. Consumers and representatives provided positive feedback regarding staffing levels and staff call bell response times. Consumers and representatives interviewed indicated they were happy with the care and services provided at the service and expressed positive feedback in relation to the new service manager and DON’s commitment to improving staffing levels and staffing mix. They indicated that there is sufficient staff who have a strong knowledge of consumers needs and preferences. Documentation reviewed and consumer and representative interviews indicated there is sufficient staff to meet their needs. The service demonstrated that there are processes to ensure workforce interactions with consumers are kind, caring and respectful of each consumers identity, culture and diversity with all consumers and representatives confirming this. Staff indicated they knew consumers well and provided examples of how they treat them with respect. Documentation reviewed reflected the service expects staff to provide respectful interactions with all consumers and value their cultural diversity. The Assessment Team observed workforce interactions that were respectful of consumers identity, culture and diversity.

The service demonstrated the workforce has the necessary qualifications to effectively perform their roles. Consumers and representatives indicated that staff were competent and had the knowledge to perform their work tasks and staff demonstrated they have the knowledge to complete their roles. The management team provided evidence staff were up to date with their competency assessments required to maintain their skills. The service demonstrated that there are processes for staff recruitment, staff orientation and for ensuring staff complete their mandatory education and training to deliver the outcomes required by the quality standards. Staff interviewed confirmed they have completed their mandatory training and that new staff commencing at the service are better equipped through a detailed orientation program. Review of a sample of staff personnel files and additional records provided by the management team showed that staff recruitment and orientation processes are being followed. Documentation provided demonstrated staff are current with their mandatory training. The service demonstrated that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

Staff interviewed indicated they had completed a performance appraisal in the past 12 months. The management team provided evidence that all performance appraisals were completed. The management team indicated they monitor staff practice in-person on an ongoing basis, undertake staff competency assessments regularly and monitor consumer and representative feedback and consumer incidents. Consumers are encouraged to give feedback on staff performance at their monthly consumer and representative forums and they are offered the opportunity to provide feedback on a 1:1 basis to the manager. Currently there are no staff being performance managed by management at the service.

**Standard 8**

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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 Quality Standard was not fully assessed, and therefore has not received a compliance rating. Three of the five specific Requirements have been assessed and found compliant.

During the Site Audit between 29 March 2022 and 4 April 2022 the organisation was unable to demonstrate that it has effective organisation-wide governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints. Information regarding the changing COVID-19 updates were not always communicated to consumers and representatives. In addition, information in consumer care and services documentation was not always correct which impacted on consumer care. The organisation did not demonstrate that there were sufficient workforce governance arrangements for managing the quality of care and services for consumers. In relation to feedback and complaints governance, there was no consistent approach to the analysing and trending of feedback and complaints data or monitoring and the review of complaint resolution actions. Complainants were not consistently asked whether they are satisfied with the outcome of their concerns. Consumer feedback/complaints and incidents were not filtered through to the Plan for Continuous Improvement (PCI).

The organisation has a documented risk management framework that defines the process to be followed to identify, assess and treat risk, however this was not always being followed by staff. Management and staff demonstrated they did not follow the serious incident response scheme (SIRS) and the legislative reporting process for one consumer. Review of the care and services documentation indicated high prevalent and high impact risks were not being managed and reviewed appropriately. Consumers with wounds are not being reviewed regularly, consumers who have had falls have not had neurological observations taken as per the organisation’s policy.

The organisation or service was unable to demonstrate that where clinical care is provided—a clinical governance framework, including but not limited to the following: antimicrobial stewardship (AMS) and minimising the use of restraint, was in place. Open disclosure was not well understood, and the principles were not consistently followed by staff.

The Assessment Team observed that the service has implemented several actions in response to the non-compliance identified at the Site Audit with transitioning to a new electronic care planning system, there is a is display stand in the reception area with internal policies on; information management, continuous improvement, feedback/complaints management and displays regulatory updates. There is information at reception on how the service manages risks within the service and what these risks are. Toolbox education was completed on AMS, restraints and open disclosure. The recruitment of a regional manager to support operational governance has been filled, this position reports to the executive level governance team.

During the Assessment Contact conducted 30 May 2023 and 1 June 2023 the Assessment Team found that the actions taken in response to the non-compliance have been effective. The service demonstrated overall, it has effective governance systems in place relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The service uses an electronic care planning management system (ECMS) to for consumer data to be recorded, monitored and evaluated, including incident data and individualised consumer care planning documentation. The organisation has a Plan for Continuous Improvement (PCI) and where appropriate, items from the service feed into the organisation’s PCI for actions and outcomes. Items in the PCI are regularly reviewed by the executive team, reported to the chief executive officer and/or board as required to ensure governance of continuous improvement. The organisation indicated there are systems in place for effective financial governance. The head of governance and risk advised there is a head of financial management at the executive level who reports to the chief executive officer who reports to the board. The board has overall responsibilities for ensuring the organisation is financially accountable and able to meet their obligations.

The organisation implemented a strategic workforce plan involving the recruitment of a head of human resources at organisational level and a human resources business partner at NSW operational level. The organisation and service have a recruitment process including induction and orientation to ensure that staff can meet the roles and responsibilities of the specified job. The organisation subscribes to an externally provider for legislative and regulatory updates. The updates are directed to the chief executive officer and to the head of governance and risk. Review of the updates occur at executive management level and policy amendments occur. Once the executive draft policies, they are sent to the board for ratification. Once policies are ratified, they are circulated to the service for implementation and staff education as needed. The organisations feedback and complaints policy include a section explaining open disclosure. Feedback and complaints are monitored by governance and compliance. High level complaints are escalated to the chief executive officer and upwards to the board for immediate oversight. The organisation demonstrated feedback and complaints are reviewed and used to improve the quality of consumer care and services.

There is an organisational risk management system and practices in place that effectively manages high impact and high prevalence risks, manages incidents and risk, identifies abuse and neglect of consumers and supports consumers to live the best quality of life they can. The Assessment Team reviewed the services incident management system which demonstrated how the service effectively manages and acts to prevent future incidents.

The organisation demonstrated there is a clinical governance framework overseen by the organisational head of governance and risk. The service has a range of policies and procedures covering a wide range of areas including AMS, restrictive practice and open disclosure.

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