**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Iris Manor |
| Commission ID: | 300904 |
| Address: | 264 High Street, ASHBURTON, Victoria, 3147 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 28 August 2024 to 29 August 2024 |
| Performance report date: | 26 September 2024 |

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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 2846 Iris Aged Care Pty Ltd  
Service: 26257 Iris Manor

**This performance report**

This performance report has been prepared by N Chahal, 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 services it operates, 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 (performance assessment) – site report was informed by a site assessment, observations at service outlets, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 24 September 2024.

# Assessment summary for Home Care Packages (HCP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

**Standard 2**

* Requirement 2(3)(a) undertake comprehensive assessment and planning through review of consumer care plans and care schedules to reflect assessed consumer risks, goals and needs.

**Standard 3**

* Requirement 3(3)(e) ensure comprehensive information sharing regarding updates to care needs.

**Standard 8**

* Requirement 8(3)(b) maintain advisory committee meetings and reporting to the Board.
* Requirement 8(3)(d) ensure consistent investigation, collation and analysis of incident data for identification of risks and appropriate strategies.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | | HCP |
| 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 |

Findings

The service was found non-compliant with this Requirement following an Assessment Contact conducted in December 2023, as not all Home Care Package (HCP) service inclusions were discussed or presented to consumers as an option. The service has implemented improvement actions since that time which have been effective.

The improvements made since the finding of non-compliance include the development of a fact sheet which outlines HCP inclusions. The information provided to consumers is accurate and timely, and consumers and representatives confirmed they can understand the information presented. There was evidence consumers are advised of allied health availability and receive statements outlining their HCP budgets. Consumers are alerted when their budgets are low, and information is provided on the costing of services to enable them to prioritise services and consider paying privately for others if needed. The Assessment Team observed information to be clear and easy to understand.

As a result, with consideration to the actions implemented by the Approved Provider I am satisfied this Requirement is compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP |
| 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. | Not 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 |

Findings

The service was found non-compliant with Requirements 2(3)(a), and 2(3)(c) following an Assessment Contact in December 2023. Since that time, the service has implemented initiatives resulting in improvements. However, deficits remain, and the Assessment Team has recommended Requirement 2(3)(a) as non-compliant.

Requirement 2(3)(a)

The Assessment Team report identified that care staff were not always aware of consumer risks and risk mitigation strategies. For some consumers, risks and needs were identified in care plans but not in care schedules, and no risk mitigation strategies were recorded. This was evident for falls risk, risks related to changed behaviours, emotional needs, the need for comprehensive assistance with activities of daily living, and needs related to vision and hearing impairment. Some consumers did not have mobility plans.

The Approved Provider has submitted a written response acknowledging the Assessment Team’s findings. The response also included supporting documentation such as a Plan for Continuous Improvement (PCI), workflow checklists and policies and procedures.

The PCI and the written response describe that the service is undertaking a review of all care plans to reflect assessed consumer risks, goals, and care needs as a priority, with a planned completion of this action by October 2024. The service has also developed detailed checklists to ensure consistent assessment and planning, and training has been provided to clinical staff. The Approved Provider described that staff receive communication through alerts from the electronic care management software.

In making my decision, I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the Assessment Contact, these actions have not been fully implemented, evaluated, and embedded. I am not satisfied that the Approved Provider has demonstrated effective assessment and planning, including consideration of risks to the consumer’s health and well-being. I find Requirement 2(3)(a) non-compliant.

Requirement 2(3)(c)

The service has implemented improvement actions since the findings of non-compliance in December 2023. These have been effective, and for this reason I am satisfied this Requirement is compliant.

Consumers and representatives indicated they are involved in assessment, review, and care planning, along with other providers of care. Representative feedback demonstrated changes to consumers’ care needs are discussed with care managers, and that care managers liaise with others involved including allied health and medical professionals, and external services. Care plan review may be prompted by consumer requests for changes. Care managers outlined that they receive reports from allied health professionals following their visits to consumers.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | | HCP |
| 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)(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. | Not 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 service was found non-compliant with Requirements 3(3)(a), 3(3)(e), and 3(3)(g), following an Assessment Contact conducted in December 2023. Following a subsequent Assessment Contact conducted in August 2024, the Assessment Team has recommended Requirements 3(3)(a) and 3(3)(e) as non-compliant. I have considered the available information and Approved Provider response and have come to a different view for Requirement 3(3)(a). I consider Requirements 3(3)(a) and 3(3)(g) are compliant and Requirement 3(3)(e) remains non-compliant.

Requirement 3(3)(a)

The Assessment Team report identified that where consumers required full assistance with personal care or mobility, the care was not being provided in accordance with their care plans. Some consumers had generic schedules which considered only the provision of personal care, domestic care, or social support and were not tailored to consumer needs. This included use of continuous oxygen, assistance with mobility, and the management of changed behaviours.

The Assessment Team noted that the service has a general risk assessment policy but did not have best practice guidelines and procedures available to guide staff in the management of falls, wounds, or changed behaviours.

Overall, consumers and representatives expressed satisfaction with the personal and clinical care they receive, indicating the care provided meets their preferences and needs. Clinical and care staff demonstrated an understanding of consumer care needs. There was evidence chemical restrictive practice is managed in accordance with legislative requirements, with monitoring and review occurring and consent obtained. Staff described the use of behaviour support plans and explained they check for potential physical causes of changed behaviour such as pain or urinary tract infection.

The Approved Provider has submitted a written response with clarifying information and supporting documentation including a PCI, workflow checklists and policies and procedures.

The Approved Provider disagrees with the Assessment Team’s findings relating to the service not having best practice guidelines and procedures available to guide staff in the management of falls, wounds, or changed behaviours. The documentation submitted by the Approved Provider demonstrated the service has a range of guidelines, procedures and policies relating to falls, changed behaviours, wounds, pain management, oral health and other areas of clinical care.

The PCI outlines a range of actions completed and planned to ensure delivery of safe and effective clinical and personal care. These include review of care plans to ensure comprehensive assessment and planning, engaging contractors for clinical reviews, appointment of a new clinical management position to provide clinical support and upcoming refresher training for staff on clinical areas of care.

In relation to the generic schedules and omittance of guidance relating to continuous oxygen use, mobility and changed behaviours. I have considered this information under Requirement 2(3)(a) which also demonstrates the absence of adequate consideration to assessment and planning.

With consideration to the available information, the Assessment Team report and the Approved Provider’s response, I am satisfied that Requirement 3(3)(a) is now compliant.

Requirement 3(3)(e)

The Assessment Team report identified that the service did not demonstrate effective documentation of consumer conditions and needs within the organisation, nor adequate communication of information to others involved in consumer care. While consumers and representatives felt communication was adequate, care documentation was observed by the Assessment Team to not consistently reflect consumers current conditions and needs. Information regarding changed behaviours was included in a care plan but not in the corresponding staff schedule; a mobility care plan lacked information regarding the level of staff assistance required; and information regarding falls risk included in a mobility care plan was not included in the corresponding staff schedule. There was also a lack of information in the care schedule regarding a consumer’s need for an interpreter for complex conversations. Information relevant to the provision of care was at times also missing from documentation sent to external providers, including information regarding cognitive impairment and communication difficulties.

Management advised not all staff attend handover meetings and stated they are addressing this issue using reminders. A handover report has also been introduced, to be printed at the end of each shift and discussed during handovers.

The Approved Provider has submitted a written response acknowledging the Assessment Team’s findings. The response also included supporting documentation such as a PCI, and policies and procedures.

The service is currently undertaking review of consumer care plans to ensure comprehensive assessment and planning is in place reflecting assessed consumer risks, goals and needs. This action is planned for completion by October 2024.

Along with updating the alerts on the electronic care management system, the service has also developed a training video guiding all staff to check for alerts and care plan updates. This has been included in the organisational onboarding process.

In making my decision, I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the Assessment Contact, these actions have not been fully implemented, evaluated, and embedded. I am not satisfied that the Approved Provider has demonstrated effective communication of consumer condition and preferences where responsibility for care is shared. I find Requirement 3(3)(e) non-compliant.

Requirement 3(3)(g)

The service has implemented improvement actions for Requirement 3(3)(g) since findings of non-compliance identified in December 2023. These have been effective, and for this reason I am satisfied this Requirement is compliant.

Consumers and representatives confirmed staff employ infection prevention and control measures, including the use of gloves and masks and the completion of hand hygiene. The service has policies and procedures in place in relation to infection prevention and control, communicable diseases, and antimicrobial use. Vaccinations are required for staff and staff undergo training in infection prevention, antimicrobial stewardship, and personal protective equipment (PPE). The Assessment Team observed PPE and hand sanitiser to be readily available.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | | HCP |
| 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 was found non-compliant with Requirements 7(3)(d) and 7(3)(e) following an Assessment Contact conducted in December 2023. The service did not demonstrate there was an effective system in place to facilitate staff training and undertake performance reviews.

The service has implemented improvement actions since that time including the development of a learning management system and the delivery of training. The service has also developed and introduced a process for performance appraisals.

Consumers and representatives were satisfied staff at the service are adequately trained. There was evidence completion of training is monitored through the new learning management system, which also allows the service to track when training is due. Staff confirmed they complete mandatory training modules and self-identify other modules to further their own development. Care staff are also accessing a Diploma of Dementia Care through an external education provider.

Management outlined a process to assess, monitor, and review staff performance. Some performance appraisals have been conducted; however, evaluation of the process has identified weaknesses relating to training needs. Appraisals have been paused to allow staff time to complete specific training modules to better equip them to actively participate in the appraisal process. The service has policies and procedures in place to guide management in monitoring and reviewing staff performance.

With consideration to the actions implemented by the Approved Provider I am satisfied these Requirements are compliant.

# Standard 8

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

Findings

The service was found non-compliant with Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d), and 8(3)(e) following an Assessment Contact in December 2023. Since that time, the service has implemented initiatives resulting in improvements. However, deficits remain, and the Assessment Team has recommended Requirements 8(3)(b) and 8(3)(d) as non-compliant. I have considered the available information and Approved Provider response and consider Requirements 8(3)(a), 8(3)(c) and 8(3)(e) are compliant and Requirements 8(3)(b) and 8(3)(d) remain non-compliant.

Requirement 8(3)(b)

During the Assessment Contact in December 2023, the service’s policies and procedures did not reflect the Aged Care Quality Standards, and its governance framework was not clearly defined. There are remaining deficits and as a result I find this Requirement non-compliant.

The service does not have a governing body which meets the membership structure required by legislation, to ensure a mix of independent members with diverse skills, experience and expertise. The executive management described their initiatives to have clinical specialists and other independent non-executive members join the Board, but these have been unsuccessful.

While the service has introduced a governance framework and a quality-of-care advisory committee, no clinical indicator data is provided to the Board or to the committee for review and oversight.

The Approved Provider has submitted a written response acknowledging the Assessment Team’s findings. The response also included supporting documentation such as a PCI, and policies and procedures.

In the response, the Approved Provider described initiating the process to appoint non-executive directors with clinical and accounting experience to meet their legislative requirements for the governing body. A clinical management position has also been established to oversee incident management systems and clinical governance systems. As an interim measure, the executive management of the service will oversee and manage the incident and feedback mechanisms.

The Approved Provider in their response has described commencement of quality advisory meetings from September 2024. These meetings will analyse and trend incident data to form a part of continuous improvement and reporting to the Board.

In making my decision, I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the Assessment Contact, these actions have not been fully implemented, evaluated, and embedded. I find Requirement 8(3)(b) non-compliant.

Requirement 8(3)(d)

The Assessment Team report identified that the service did not demonstrate effective risk management systems, policies and practices. There are remaining deficits, and as a result I find this Requirement non-compliant.

The service’s electronic care management system contains incident management functionalities; however, the service did not demonstrate that all recorded incidents are investigated, analysed, and addressed via corrective actions. While management described discussing management strategies following a fall, no investigation, analysis or corrective actions were recorded related to a fall-related incident report. The service does not routinely collate or analyse incident data. The Assessment Team report also identified that the service does not have a falls management policy to guide staff practice.

Staff at the service are able to identify incidents of abuse or neglect, and outlined how such issues would be escalated within the service.

The Approved Provider submitted a written response acknowledging the Assessment Team’s findings. The response also included supporting documentation such as a PCI, and policies and procedures.

The PCI details the actions planned and completed by the Approved Provider. These include organising refresher training for management on incident management systems, scheduling quality advisory meetings to analyse and trend incident data, reviewing consumer care plans and updating care plan alerts.

The Approved Provider disagrees with the Assessment Team’s findings relating to not having a falls management policy in place. They submitted evidence demonstrating a range of guidelines and policies and procedures. I have also considered this information under Requirement 3(3)(a).

In making my decision, I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the Assessment Contact, these actions have not been fully implemented, evaluated, and embedded. I find Requirement 8(3)(d) non-compliant.

Compliance with remaining Requirements

The service was found non-compliant with Requirements 8(3)(a), 8(3)(c), and 8(3)(e), following an Assessment Contact in December 2023. Since then, the service has undertaken improvement actions which have been effective and as such I find these Requirements compliant.

Most representatives felt they were engaged in care planning and indicated they feel comfortable to provide feedback to the service. There was evidence the service has a consumer advisory body and there was representative feedback that membership is viewed as an opportunity to contribute to positive change.

The service has purchased a suite of policies and procedures and is working with an external consultant to modify these as required. Each policy and procedure are being reviewed to ensure guidance is appropriate for staff at the service. Staff confirmed they are able to access relevant policies and procedures and have access to accurate information specific to their roles through the electronic care management system.

Corporate financial statements for the service are prepared and reviewed by an external auditor. Staff described procedures in relation to unspent HCP funds, outlining how information is provided to consumers and representatives to ensure they understand their budgets.

The service has implemented a learning management system that enables personalisation of learning modules, monitors staff completion rates, and facilitates the tracking of when training is due. Management have implemented strategies to ensure staff accept the online delivery of training. The service monitors staff qualifications and compliance with mandatory training requirements, police checks, and professional registrations.

The service has engaged an external consultant who monitors legislative changes and provides updates to the service for dissemination to staff.

The service has policies and procedures in relation to open disclosure and minimising the use of restraint. Staff receive training in open disclosure, restrictive practice, and the Serious Incident Response Scheme (SIRS). They are aware of open disclosure principles, and these are employed at the service when required. Staff understand the potential harm associated with restrictive practices and understand how to minimise the use of restraint. The service has identified consumers subject to restrictive practice, and these consumers have behaviour support plans in place, with evidence of informed consent and ongoing review in accordance with legislative requirements.

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