Performance

Report

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| Name: | IRT St Georges Basin |
| Commission ID: | 0343 |
| Address: | 87 Loralyn Avenue, ST GEORGES BASIN, New South Wales, 2540 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 31 October 2023 to 1 November 2023 |
| Performance report date: | 18 December 2023 |
| Service included in this assessment: | Provider: 835 Illawarra Retirement Trust  Service: 359 IRT St Georges Basin |

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 IRT St Georges Basin (**the service**) has been prepared by J Durston, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 7 December 2023.

# 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 Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

* Requirement 3(3)(a) – The approved provider ensures clinical and care staff receive training on managing challenging behaviours, behaviour support plans, falls prevention and post falls management, chemical restraint, pain, management wounds and medication management, and SIRS; and that the training includes completion of competency assessments and ensures each participant is supported to effectively apply their learning on the job.
* Requirement 6(3)(c) – The approved provider ensures management and staff receive training on effective complaints management and ensure that all consumer/representative complaints are recorded in the complaints management system, and are followed up, responded to and outcomes are evaluated.
* Requirement 6(3)(c) – The approved provider ensures that all complaints regarding serious incidents including risk to the health safety and wellbeing of consumers are documented in incident reports, escalated to management and a SIRS notification is completed and submitted to the Commission.
* Requirement 7(3)(d) – Refer to clinical and care staff training in Requirements 3(3)(a) and 6(3)(c).
* Requirement 7(3)(e) – The approved provider ensures all staff and management performance appraisals are completed and up to date within 3 months (as per the PCI).
* Requirement 8(3)(c) – The approved provider ensures the organisation’s incident management and workforce review frameworks, systems and processes are successfully implemented at the service level and the governing body monitors their effectiveness.
* Requirement 8(3)(d) – The approved provider ensures the governing body is provided with timely information on trends in high impact high prevalence risks to the health safety and wellbeing of consumers at the service, and the governing body monitors that risk and incident management procedures are being effectively implemented to resolve and mitigate similar risks and incidents in the future.

# Other relevant matters

The approved provider has submitted a comprehensive plan for continuous improvement that addresses the areas for improvement identified above.

# 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 |

Findings

The service was found non-compliant in Requirement 1(3)(a) following a site audit from 27 to 29 June 2022. The service did not demonstrate each consumer was treated with dignity and respect. Some consumers said staff shortages had resulted in unkind staff behaviour, consumers rushed in their activities of daily living, and staff lacked awareness of individual consumers’ preferences.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of several actions in its plan for continuous improvement (PCI) to address the identified non-compliance with this requirement. These include development of a diversity services and inclusion catering calendar, reporting on the nationalities, religions and indigenous status of residents, in August 2023, with details forwarded to the catering manager, filing newsletters, activity calendars and training guides in an agreed location. And 3 monthly audits of lifestyle activity calendars and newsletters.

During the Assessment Contact the Assessment Team found the service did not demonstrate each consumer is treated with dignity and respect. Consumer and representative feedback and observation of staff interactions with consumers indicated most staff are kind and caring and treat consumers respectfully. However, some consumers and representatives noted a staff member who spoke rudely to them, staff did not meet consumers’ personal hygiene and continence care preferences and needs, and consumer bathrooms were left unclean. The Assessment Team noted some of the language used in care planning documentation was not respectful nor person-centred.

In their response to the Assessment Team Report, the approved provider outlined the actions planned and implemented to address the Assessment Team’s feedback and supplied documentary evidence of the improvements already completed. Formal performance management action was commenced for 4 employees which resulted in 3 staff members leaving the service and another still under investigation. Mandatory face-to-face training has been organised on dignity and respect, to be embedded in practice with dignity and respect an agenda item in daily team huddles. The service is reviewing all assessments to ensure the removal of non-person-centred language. The service outlined the actions taken to address issues raised in relation to named consumers, such as reinforcing the daily tidy room checklist within staff huddles with random audit checks, review of consumers’ care plans in consultation with consumers and representatives to update areas such as personal hygiene preferences.

I acknowledge the deficits raised in the Assessment Team report regarding this requirement. However, I commend the approved provider for the extensive work it has already done and its planned PCI actions to address these deficits at systemic and consumer-centred levels.

Accordingly, I find Requirement 1(3)(a) compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The service was found non-compliant in Requirements 3(3)(a) and 3(3)(f) following a site audit from 27 to 29 June 2022.

Requirement 3(3)(a)

During the 2022 site audit the service did not demonstrate each consumer receives safe and effective clinical and personal care. There was mixed consumer feedback regarding their care. Some consumers and representatives advised their care plans were consistently not followed by staff.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. The care planning procedure was updated and implemented, and a post falls management checklist, and call bell analysis weekly review were endorsed in August 2023.

During the Assessment Contact the Assessment Team found feedback provided by consumers and representatives and clinical documentation showed some consumers were happy with their clinical and personal care. While others said their care and services were not safe and effective in areas including, managing challenging behaviours, falls, chemical restraint, pain, wounds and medications. Most medications did not have an indication for administration documented in the medication chart, some medications were not administered as per instructed timeframes. In some instances, consumers’ pain was not monitored pre and post analgesia. Or when monitoring the effectiveness of analgesia administered, staff did not follow-up, monitor, review pain relieving interventions when the analgesia was noted to be ineffective. Care documentation showed gaps in post fall neurological observations and monitoring for unwitnessed falls. Overall documentation of wounds was not clear including lack of identification, description and measurements. The supervision and monitoring instructions for one consumer with challenging behaviours were not consistently followed resulting in unwitnessed behavioural incidents. Care documentation showed trialling of alternative strategies prior to administration of antipsychotic medications did not always occur and behavioural support plans were not always followed by staff.

During the Assessment Contact management advised the service’s PCI includes information about planned improvements in relation to the administration of antipsychotic medication. Review of the PCI shows chemical restraint reduction has been identified as an issue and planned actions included sourcing medical officers who will provide face-to-face consultations with a priority focus on reducing chemical restraint.

In their response to the Assessment Team report, the approved provider outlined the improvement initiatives actioned and supplied documentary evidence in response to the findings of Assessment Team report. A mandatory face-to-face training plan was implemented covering topics including clinical deterioration, medication and pain, falls prevention and post falls management, dementia, behaviour support plans and psychotropic medications, wound and skin care and the Serious Incident Response Scheme (SIRS). The approved provider advised all residents are undergoing a full care plan and assessment review over the next 3 months, to include a holistic case conference with the resident, family clinical and hospitality and lifestyle managers, with 6 case conferences completed to date and a further 4 to be scheduled. The approved provider detailed the improvements made in the care of specific consumers in relation to the key deficiencies identified in the Assessment Team report supported by documentary evidence. The approved provider noted the continuous improvement plan for clinical care is being implemented with the support of their Quality Compliance and Learning and Development teams, and acknowledged the plan will take time to be embedded.

I commend the actions taken by the approved provider and planned improvements to return to compliance in this requirement. However, I agree with the approved provider’s response that it will take time for these improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 3(3)(a) non-compliant.

Requirement 3(3)(f)

During the 2022 site audit the service did not demonstrate timely and appropriate referrals were made to other organisations and providers of care and services. Several consumers advised they did not receive the podiatry care they needed.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. An organisational podiatry agreement was completed in September 2023 including a schedule of site podiatry visits. A contract was established for medical services, and telehealth was made available one day per week. Monthly on-site clinics were implemented for consumers.

During the Assessment Contact the Assessment Team found consumer care and service documentation showed the service works with a range of health and allied health services such as the service physiotherapist, speech pathologist and geriatricians. Care planning showed a medical officer and nurse practitioner were involved in palliative care provision, and consumers diagnosed with diabetes mellitus are reviewed by a podiatrist every six weeks.

In their response to the Assessment Team report, the approved provider did not provide a specific response to this requirement. However, the Assessment Team’s findings confirm there has been a return to compliance.

Accordingly, I find Requirement 3(3)(f) compliant.

# 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found non-compliant in Requirements 6(3)(a), 6(3)(c), and 6(3)(d) following a site audit from 27 to 29 June 2022.

Requirement 6(3)(a)

During the 2022 site audit the service did not demonstrate consumers, their family, carers and others are encouraged and assisted to provide feedback and complaints. Consumers and representatives provided mixed feedback regarding whether the service took actions in response to their feedback and complaints. Some consumers advised they felt uncomfortable or dismissed after raising concerns.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. An extraordinary resident/relative meeting was held to explain the avenues of feedback and complaints and to provide assurance that complaints could be anonymous. The PCI also contained actions to reinforce with administrative staff the process of clearing suggestion boxes, registering all feedback and complaints, providing information about advocacy and other support services to consumers and representatives, and a webinar for consumers by the Older Person’s Advocacy Network was arranged.

During the Assessment Contact the Assessment Team found most consumers and representatives interviewed who had provided feedback or made a complaint reported they felt encouraged and supported to do so and others said they thought they would be encouraged and supported should they wish to do so. One representative who raised concerns their relative was approached by the service after being interviewed by a previous Assessment Team. Management confirmed all consumers were interviewed after the last visit to seek their feedback. Information about avenues for providing feedback and complaints have been promoted to consumers and representatives, including reminders at resident/relative meetings, and their access has been facilitated through surveys. Minutes of consumer/relative meetings and recent survey results showed the service has sought feedback from consumers and their representatives. However, some complaints made by consumers about serious incidents have not been escalated and were not actioned in a timely manner or at all. This is addressed in Requirement 6(3)(c).

In their response to the Assessment Team report, the approved provider did not provide a specific response to this requirement. However, the Assessment Team’s findings confirm there has been a return to compliance.

Accordingly, I find Requirement 6(3)(a) compliant.

Requirement 6(3)(c)

During the 2022 site audit the service did not demonstrate appropriate action was taken in response to complaints and nor did open disclosure occur when things went wrong. Some consumers reported they raised feedback or made complaints, but timely action was not taken, or no action occurred. Staff did not always document complaints and indicated verbal complaints were not documented. Staff were aware of the principles of open disclosure but were unable to provide practical examples.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. A monthly review of the complaints register was introduced and staff training was delivered on complaints handling. Service leadership were provided refresher training on feedback and complaints management and open disclosure.

During the Assessment Contact the Assessment Team found appropriate action is not always taken in response to consumer/representative complaints. Some consumers and representatives advised their complaints had been satisfactorily resolved, but others did not. Complaint documentation did not consistently show that appropriate action is taken in response to complaints. Evaluation of the effectiveness of actions taken to resolve complaints was not demonstrated in documentation or management interviews. Staff had documented some complaints made by consumers about serious incidents but did not escalate them for appropriate action to be taken in a timely manner. One representative said they did not know if their complaint had been resolved because the service had not got back to them about their complaint from the previous month. Another representative said the service had not responded to their recent complaint. Some complaints made by consumers about serious behavioural incidents were documented by staff in consumer care and service records but not always in incident reports and were not escalated to management. As a result, appropriate action was not taken in a timely manner or at all, to ensure the health safety and wellbeing of consumers.

In their response to the Assessment Team report, the approved provider advised the local management team at the service have conducted a review of all feedback and complaints received at the service from April 2023 to the present. They have re-opened a number of items on the feedback and complaints register that the operations manager felt were not managed appropriately. Case conferences have been arranged with all residents and/or representatives named in the Assessment Team report to discuss their concerns and ensure they are addressed to the satisfaction of all parties. The approved provider noted that one complaint regarding a serious behavioural incident was reported as a SIRS incident the day after the complaint was made, outlined the actions taken to minimise the risk of reoccurrence of similar incidents in the future. The approved provider advised there have been no similar incidents for either of the residents and confirmed a finalisation notice was received by the Commission in November 2023.

The approved provider advised that the 2 serious behavioural incidents escalated to management by the Assessment Team during the Assessment Contact were reported as SIRS incidents to the Commission. Education on SIRS reporting and incident management was provided to staff to increase their awareness of incident escalation in accordance with the organisation’s incident management framework, and incidents and SIRS are discussed in daily staff huddles.

I commend the actions taken by the approved provider and planned improvements to return to compliance in this requirement. However, I note that a number of key actions such as case conferences in relation to consumer/representative complaints, that were deemed by the operations manager as not previously managed effectively, are still to take place. I also place weight on the Assessment Team’s findings and alerts to management during the Assessment Contact regarding 2 complaints about a consumer’s aggressive behaviours towards other consumers that were not escalated by staff in a timely manner. I consider it will take time for the improvements outlined by the approved provider to be embedded and sustained in practice.

Accordingly, I find Requirement 6(3)(c) non-compliant.

Requirement 6(3)(d)

During the 2022 site audit the service did not demonstrate feedback and complaints were reviewed and informed improvements in the quality of care and services. Some consumers said they had not noticed improvements following their feedback and complaints. Staff did not consistently explain how feedback and complaints informed the service’s PCI.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. This included the introduction of monthly feedback and complaints review meetings.

During the Assessment Contact the Assessment Team found that overall the service demonstrated it is reviewing and using feedback and complaints to inform continuous improvement of care and services. The Assessment Team received positive feedback from consumers and representatives regarding improvements to meals, cleaning and lifestyle activities, previously noted as consumer and representative concerns in minutes of resident relative meetings, consumer surveys and the feedback and complaints register. However, there were some consumers and representatives that expressed concerns about the meals and meals service.

In their response to the Assessment Team report, the approved provider did not provide a specific response to this requirement. However, the Assessment Team’s findings confirm that overall, there has been a return to compliance.

Accordingly, I find Requirement 6(3)(d) compliant.

# 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The service was found non-compliant in Requirements 7(3)(a), 7(3)(b), 7(3)(d), 7(3)(e) following a site audit from 27 to 29 June 2022.

Requirement 7(3)(a)

During the 2022 site audit the service did not demonstrate the number and mix of staff promoted the delivery of safe and quality care and services. Consumers advised staff shortages meant their activities of daily living were rushed and they had to wait when experiencing pain. Care staff described staff shortages impacting their ability to provide satisfactory care to consumers. Management outlined actions taken to alleviate staff shortages, but consumer and staff feedback indicated these strategies were not completely effective.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. The master and working day rosters are continuously reviewed. Workforce retention strategies have been implemented, and there has been ongoing recruitment and extended rosters and agency personnel used to cover vacant shifts and unplanned leave. Staff have been trained to work across multiple areas including cleaning, catering and laundry.

During the Assessment Contact the Assessment Team found documentation showed that workforce planning was confirmed during interview with management. The master roster is being continually reviewed, new positions have been created, staffing hours have increased, and there has been ongoing recruitment with new staff on-boarded. Most rostered shifts are being filled, mostly with the service’s own staff. Agency personnel usage has decreased but remains significant. To attract and retain staff, accommodation has been made available on-site for staff from overseas and for agency personnel. Most consumer call bell response times show they are answered in a timely manner, and exceptions are followed up by management. Most staff interviewed advised there is the right mix of staff to provide consumers with the care and services to meet their needs and preferences.

However, the Assessment Team found that although there is evidence that workforce planning is occurring, it has not been effective in managing the delivery safe and quality care and services for consumers. Particularly in areas such as providing adequate supervision, monitoring and support for consumers with aggressive behaviours, and consumers who are at high falls risk, or needing assistance with personal care and to eat and drink. One RN advised that having one registered nurse on duty for the whole service was not sufficient to effectively monitor safe medication management in low care areas of the service, which had resulted in medication incidents.

In their response to the Assessment Team report, the approved provider supplied staffing reports as evidence to show it has significantly increased the service’s skill mix particularly from Aged Care Certificate level 1 to Aged Care Certificate level 2 qualified staff between 1 October 2023 to 26 November 2023. It also provided a staffing report evidencing an increase in agency registered nurses for the fortnight ending 26 November 2023 to provide extra coverage for the leave and onboarding of two new permanent registered nurses recruited to the service.

The approved provider also noted that during the Assessment Contact, they advised the Assessment Team that management was in the process of reviewing the master roster including the staff skill mix required per shift, acknowledged additional hours were required for one afternoon shift and had put interim staffing measures in place until the revised roster was implemented. In addition, in their response the approved provider confirmed that from 27 November 2023 one additional registered nurse was added to the day shift and one to the afternoon shift to increase clinical monitoring and support. Four aged care employee shifts have been added to the in the memory support units – equating to 2 additional staff per day shift and 2 per afternoon shift to increase supervision and monitoring of residents. Case conferences have been scheduled with residents and representatives to discuss and reassure them of the staffing levels and workforce management strategies in place.

I acknowledge the deficits raised by the Assessment Team regarding staff numbers and skill mix at the service, and the feedback from consumers and representatives regarding the negative impacts this had for consumer care and services. However, I give more weight to the actions taken by the approved provider, supported by documentary evidence, since the Assessment Contact, including successful recruitment of additional registered nurses, review and revision of the master roster to resolve the specific staffing deficits identified in the Assessment Team report, and the evidence provided in relation to the positive results of the staff upskilling program between October and November 2023.

Accordingly, I find Requirement 7(3)(a) compliant.

Requirement 7(3)(b)

During the 2022 site audit the service did not demonstrate the workforce was interacting with consumers in a kind, caring and respectful manner. Some staff in the memory support unit were observed rushing consumers at mealtimes and not speaking respectfully about them.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. The service introduced a new buddy program for all new care staff. Staff received education on privacy dignity and personal care check-ins, and employees’ interactions with consumers were monitored and acceptable behaviours were reinforced.

During the Assessment Contact the Assessment Team found that overall, the service demonstrated consumers are treated with kindness and respect by staff. Most consumers and representatives advised that staff are kind, caring and respectful towards consumers. Staff were observed interacting with consumers in a kind and respectful manner, and staff spoke respectfully about consumers when interviewed. Staff have had training on the code of conduct and organisational values including kindness, an most staff have completed their personal care competency that includes dignity in care. However, it was reported that some of the workforce have not treated consumers respectfully. This was addressed in Requirement 1(3)(a).

In their response to the Assessment Team report, the approved provider did not provide a specific response to this requirement. However, the Assessment Team’s findings confirm that overall, there has been a return to compliance.

Accordingly, I find Requirement 7(3)(b) is compliant.

Requirement 7(3)(d)

During the 2022 site audit the service did not demonstrate its workforce was sufficiently trained to deliver the outcomes required by the standards in the areas of recording complaints, respectful behaviours and SIRS.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. The gaps in staff training were reviewed. Buddy training was delivered to senior employees to train new staff, and weekly staff check-in meetings were held.

During the Assessment Contact the Assessment Team found that staff are equipped and supported through orientation and some training and competency assessments to deliver the outcomes required by the Quality Standards. However, some consumers and representatives advised more staff training was needed in areas such as cleaning. Overall, training documentation showed some training and competency assessments were not well attended in areas such as fire safety and code of conduct. The Assessment Team noted some staff assessed as competent in medication management were observed to make medication errors that posed a risk to consumers health and safety. There were areas of care and services found to have significant deficits despite related training being well attended, including minimising restrictive practices and SIRS.

The Assessment Team found documentation showed, that staff are being recruited in a manner consistent with the organisation’s recruitment processes. However, orientation checklists for 2 staff who commenced in July 2023 were not located in their personnel files, which management said they would follow up.

In their response to the Assessment Team report, the approved provider disagreed that its staff training is ineffective. The approved provider noted the Assessment report focused on 4 employees which is not a true reflection of all staff knowledge and capability in delivering services. The approved provider advised that the employees identified as either not following or who lacked knowledge of correct policy and procedure were required to attend training during the Assessment Contact and their medication competency was reassessed the following week.

The approved provider advised that the Assessment Team incorrectly concluded that a staff member’s response to a question on fire safety was inaccurate, noting that their answer was consistent with the organisation’s process. The approved provider confirmed the two staff noted in the report attended fire training with 9 other staff in late November 2023, and provided documentary evidence of the 2 missing completed orientation checklists that were not provided in the Assessment Contact. The approved provider advised that the code of conduct online training is required to be completed by staff within 12 months. Hence the number of non- completions noted in the assessment report did not apply because they fell within the 12-month period.

The approved provider advised the service has modified its mandatory education delivery method to improve staff understanding and practical application of learnings in the workplace. All training is now delivered face-to-face with a quiz or competency assessment at the end and is followed up by an on-the-job coaching session. One-on-one competency assessments were conducted by the clinical nurse educator at the beginning of December 2023 with another date scheduled for the following week.

I acknowledge the issues raised in the approved provider’s response to the Assessment Team report. I acknowledge the deficits raised regarding staff training in the Assessment Team report. While I acknowledge that the 4 employees interviewed by the Assessment Team in relation to training does not represent a large proportion of actual staff numbers, I note, based on the report, those interviews were considered in conjunction with observations and interviews with other staff in relation to care and service practices covered in training they had attended. I commend the improvements made to the organisation’s training methodology including post training competence assessment and closing the loop with follow-up to ensure transfer of learning to the workplace. However, I consider further time will be required to consolidate these improvements to be reflected in sustained performance.

Accordingly, I find Requirement 7(3)(d) is non-compliant.

Requirement 7(3)(e)

During the 2022 site audit the service did not demonstrate regular assessment monitoring and review of each staff member’s performance. The service had performance monitoring processes in place and appraisals were being regularly completed, but the Assessment Team found deficits in record keeping and performance management.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. Management observes staff practice on the floor. Comments and complaints are reviewed for relevance to staff performance. There is a system in place to monitor that staff assessments and clinical documentation are up to date. Education referrals are made to address deficits in staff performance. Performance development and reviews are conducted for staff and the service is using the performance management pathway where necessary.

During the Assessment Contact the Assessment Team found that performance review reports and staff interviews showed that regular performance review for all staff has not occurred and there has been a lack of effective oversight of performance review completions. However there has been improvement demonstrated in the management of performance when things go wrong. Review of documentation regarding 2 consumer complaints made in 2023 and management interviews showed appropriate and timely performance management responses.

In their response to the Assessment Team report, the approved provider acknowledged the performance review procedure has not been actively followed at the service and has been a contributing factor in the concerns raised regarding how some staff are delivering care and services. The local and human resources team have developed an improvement plan to ensure all staff have a meaningful face-to-face performance review meeting and plan in place within the next 3 months for the service to return to full compliance with this requirement by February 2024.

I acknowledge the approved provider’s response and the actions it is implementing to return to compliance in this requirement. However, I consider it will take time for these actions to be completed and embedded in ongoing practice.

Accordingly, I find Requirement 7(3)(e) non-compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not 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 |

Findings

The service was found non-compliant in Requirements 8 (3)(a), 8(3)(c), 8(3)(d) following a site audit from 27 to 29 June 2022. The service did not demonstrate.

Requirement 8(3)(a)

During the 2022 site audit the service did not demonstrate consumers were consistently engaged in delivery and evaluation of care and services. Some consumers did not consider the service was well run, and advised follow-up actions did not occur after consumer meetings, and complaints did not consistently result in improvements.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. The service reminded consumers at the resident/relative meeting about information sharing and involvement in care. Consumers were surveyed to seek their feedback. Monitoring care evaluations took place, consumer case conferences were held and care plans shared on request.

During the Assessment Contact the Assessment Team found the service demonstrated it engaged and supported consumers to provide input into care and services. Consumers and representatives interviewed generally thought the service was well run and it engaged them as partners in care through case conferences and input to care planning. They also reported opportunities to provide input in how care and services operate across the service, including the menu, activities and the environment. The CEO and other executives provided examples of being responsive to consumer feedback and improvements being made, with support from the governing body and this was confirmed via other information sources. The CEO advised that a consumer advisory committee is being formed and documentation confirmed this.

In their response to the Assessment Team report, the approved provider did not provide a specific response to this requirement. However, the Assessment Team’s findings confirm that overall, there has been a return to compliance.

Accordingly, I find Requirement 8(3)(a) compliant.

Requirement 8(3)(b)

During the 2022 site audit the service did not demonstrate the governing body promoted and a culture of safe, inclusive and quality care and services. However, the frameworks were not effectively implemented or applied by the service, and consumer feedback reflected concerns about inclusivity and quality had been ongoing without satisfactory resolution

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. Staff are trained in personal care check-in. Consumer suggestion boxes are checked weekly and the service seeks feedback from consumers to monitor the effectiveness and care and services.

During the Assessment Contact the Assessment Team found the CEO advised and documentation showed that strategic planning is undertaken with direction and involvement of the governing body and that operational planning is undertaken in line with the strategic plan. The strategic goals and initiatives include safe, inclusive and quality care. The strategic plan is promoted to staff and management by board member and executive road shows, and expectations are also communicated through a strategic plan on a page document, policies, procedures and committees and staff updates. There are clear lines of accountability specified in plans, policies and procedures. A framework was developed for the executives to report to the governing body on progress and achievements against the strategic priorities. There is a risk rating system. When the need for improvement is identified, the governing body receives information about this and the actions are planned and undertaken

In their response to the Assessment Team report, the approved provider did not provide a specific response to this requirement. However, the Assessment Team’s findings confirm that overall, there has been a return to compliance.

Accordingly, I find Requirement 8(3)(b) compliant.

Requirement 8(3)(c)

During the 2022 site audit the service did not demonstrate effective governance systems for feedback and complaints and workforce governance. There were deficits in recording feedback and complaints and using them to inform continuous improvement initiatives.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. Staff training was delivered on incident identification and escalation. The service continues to remind consumers about SIRS, and workforce management systems and processes are continuously monitored for effectiveness.

During the Assessment Contact the Assessment Team found while effective governance has been demonstrated in relation to financial governance, it has not been demonstrated in relation to aspects of information management, continuous improvement, workforce governance, and regulatory compliance in relation to feedback and complaints. Although there are framework documents, policies and procedures to communicate expectations and assign responsibilities regarding these areas, organisational systems and processes are not being effectively implemented at the local level, particularly in relation to incident escalation and management and workforce review.

In their response to the Assessment Team report, the approved provider advised it recognised the issues raised by the Assessment Team in relation to this requirement, and outlined the improvement actions it has and will undertake to address the deficits, including changes to some key personnel. The approved provider advised it has brought into the service a highly experienced care manager who has extensive understanding of the organisation’s policies and procedures. The approved provider noted the operations manager who commenced in the role a month before the Assessment Contact, is highly competent and specialises in returning centres to compliance. The approved provider advised they are confident of a return to compliance will be achieved through the delivery of the PCI within 3 months, and the majority of planned actions across the requirements are in progress.

I have reviewed the PCI submitted by the approved provider in their response, and I am satisfied it reflects the required areas for improvement identified in the Assessment Team report. I consider it will take time to return to compliance in this requirement. As advised in their response, the approved provider aims to achieve a sustainable result at the service through governance that ensures effective, quality and safe care is delivered to consumers within a three-month improvement timeframe.

Accordingly, I find Requirement 8(3)(c) non-compliant.

Requirement 8(3)(d)

During the 2022 site audit the service did not demonstrate effective risk management systems in the areas of risk management practices, there were deficits regarding incident and risk management, responding to abuse, and supporting consumers to live their best lives.

During the Assessment Contact conducted from 31 October to 1 November 2023, the service provided evidence of actions in its PCI to address the identified non-compliance with this requirement. Refresher training was delivered to staff on identifying and reporting serious incidents, and management received training about identifying and managing incidents and monitoring effectiveness of incident management. Feedback and complaints were reviewed to identify areas impacting consumer care and services requiring improvement, and consumers were reminded of how provide feedback and complaints.

During the Assessment Contact the Assessment Team found the organisation’s risk management framework has been effective in identifying many risks relating to service performance against the Quality Standards. However, some risks have not been identified or fully understood and it has not been demonstrated that some risks have been managed effectively. This is due to organisational systems and processes not effectively implemented at the service. The Assessment Team found that chemical restraint is not always used as a last resort. The number of consumers experiencing falls has increased in the last 4 quarters, even though governance meeting minutes noted close monitoring of residents at risk of falls was required. Requirements 3(3)(a) and 7(3)(a) evidenced that falls risks have not been managed effectively for some consumers.

The organisation’s incident framework and processes for managing and preventing incidents of abuse and neglect have been strengthened but are not completely effective. The governing body confirmed it had not received information about recent significant incidents of aggression by one consumer at the service.

In their response to the Assessment Team report, the approved provider outlined and provided evidence of the extensive implementation strategy undertaken to introduce the organisation’s new incident management framework in May 2023 for staff, management, consumers and their representatives, but acknowledged the framework had not been fully embedded at the service. The approved provider confirmed it is now reinforcing the procedures through mandatory education as part of the compliance education plan. High risk case management processes are in place at the service for identified consumers that include case conferencing multidisciplinary collaboration and senior clinical oversight. In addition to the experienced care manager who has commenced at the service, a senior clinical nurse educator will be regularly based there to provide additional guidance to clinical staff on the floor, and a senior clinical manager from another region will assist the care manager to review complex cases and serious incidents as required.

I commend the extensive actions the approved provider is taking to strengthen its risk management framework and practices. However, I consider the approved provider will require time to fully embed the changes in practice.

Accordingly, I find Requirement 8(3)(d) non-compliant.

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)