Performance

Report

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| Name: | Jonathan Rogers GC House |
| Commission ID: | 0821 |
| Address: | 124 Wallace Street, Nowra, New South Wales, 2541 |
| Activity type: | Review Audit |
| Activity date: | 3 November 2023 to 8 November 2023 |
| Performance report date: | 5 January 2024 |
| Service included in this assessment: | Provider: 643 RSL LifeCare Limited  Service: 5875 Jonathan Rogers GC House |

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 Jonathan Rogers GC House (**the service**) has been prepared by E Woodley, 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 Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers, representatives, and others.
* the provider’s response to the assessment team’s report received 13 December 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **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 1(3)(a) – the approved provider must demonstrate all consumers are treated with dignity and respect, and staff are aware of and value consumer’s identity, culture and diversity. Staff practices and workforce planning is effective in ensuring respectful and dignified care and services for consumers.
* Requirement 1(3)(c) – the approved provider must demonstrate each consumer is supported to exercise choice and independence regarding their care and services, and these choices are upheld by the service. Consumer’s choices regarding the extent to which they want representatives to be involved in their care is communicated and respected by the service.
* Requirement 2(3)(a) – the approved provider must demonstrate assessment and planning considers risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services. Assessments to identify risks and inform safe care are completed in a timely manner, and by specified members of the workforce, in line with the organisation’s policies.
* Requirement 2(3)(b) – the approved provider must demonstrate assessment and planning consistently addresses the needs, goals and preferences of consumers, including advanced care planning and end of life planning if the consumer wishes. All consumers have the opportunity to discuss advanced care planning, and consumers who have needs, goals and preferences in relation to advanced care or end of life have these identified and documented in care planning documentation.
* Requirement 2(3)(c) – the approved provider must demonstrate assessment and planning is based on an ongoing partnership with consumers and representatives who the consumer wishes to involve in their care. Where assessment and planning includes other providers of care, these assessments are considered to inform the consumer’s care and service delivery.
* Requirement 2(3)(d) – the approved provider must demonstrate consumer care plans include sufficient information to guide staff in the delivery of safe and effective care to meet consumer needs, goals and preferences. Consumers and relevant representatives are aware they can access consumer care and service plans if they wish.
* Requirement 2(3)(e) – the approved provider must demonstrate care and services are reviewed for effectiveness when circumstances change or incidents impact on the needs, goals or preferences of the consumer. Incidents are investigated to assist in identifying interventions to minimise risk of reoccurrence and to support safe care.
* Requirement 3(3)(a) – the approved provider must demonstrate consumer clinical and personal care is best practice, tailored to the consumer’s needs and optimises their health and well-being. Chemical restrictive practice processes are best practice, including used as a last resort after tailored non-pharmacological interventions to manage behaviour are evaluated as not effective. Consumer pain and behaviours requiring support is appropriately assessed, managed and monitored to optimise their health and well-being.
* Requirement 3(3)(b) – the approved provider must demonstrate the high impact or high prevalence risks associated with the care of consumers are effectively identified and managed. This includes risks associated with behaviours requiring support, choking, falls and pressure injuries.
* Requirement 3(3)(c) – the approved provider must demonstrate the needs, goals and preferences of consumers nearing end of life are recognised and addressed in a timely manner. The comfort and dignity of each consumer nearing end of life is maximised.
* Requirement 3(3)(d) – the approved provider must demonstrate deterioration or change of a consumer’s condition is recognised and responded to in a timely manner by the service.
* Requirement 3(3)(e) – the approved provider must demonstrate information about the consumer’s condition, needs and preferences is documented and communicated effectively to ensure it is communicated to staff and others responsible for the consumer’s care.
* Requirement 3(3)(g) – the approved provider must demonstrate the service has implemented practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. Standard and transmission based precautions to prevent and control infection are effectively implemented at the service. The service keeps informed, and follows, appropriate infection prevention and control practices, and health orders and recommendations in relation to infection-related risks.
* Requirement 4(3)(a) – the approved provider must demonstrate services and supports for daily living meet each consumer’s needs, goals and preferences, and optimise their independence, health, well-being and quality of life.
* Requirement 4(3)(b) – the approved provider must demonstrate services and supports promote each consumer’s emotional and psychological well-being following events that may have triggered an emotional or psychological impact for consumers.
* Requirement 4(3)(d) – the approved provider must demonstrate information related to consumer’s conditions, needs and preferences for daily living is effectively communicated within the service to all those responsible for care.
* Requirement 4(3)(f) – the approved provider must demonstrate meals provided by the service are consistently of suitable quality and quantity, and in line with consumer needs and preferences.
* Requirement 5(3)(c) – the approved provider must demonstrate furniture fittings and equipment are safe, clean and well maintained. The service has effective processes in place to identify and actions risks to the safety, cleanliness and maintenance of furniture, fittings and equipment.
* Requirement 6(3)(a) – the approved provider must demonstrate consumers and representatives are encouraged and supported to provide feedback and make complaints.
* Requirement 6(3)(c) – the approved provider must demonstrate appropriate action and an open disclosure process is consistently used in response to complaints or incidents. The service has processes to ensure accurate complaints documentation to assist with resolution, review, and evaluation of complaint trends.
* Requirement 6(3)(d) – the approved provider must demonstrate feedback and complaints are effectively reviewed, trended or analysed, and used to improve the quality of care and services.
* Requirement 7(3)(a) – the approved provider must demonstrate the workforce deployed enables the delivery and management of safe and quality care and services. The service has effective processes in place to manage unfilled shifts without compromising quality consumer care and services.
* Requirement 7(3)(b) – the approved provider must demonstrate workforce interactions with consumers are consistently kind, caring and respectful of each consumer’s identity, culture and diversity.
* Requirement 7(3)(c) – the approved provider must demonstrate staff are competent and have the knowledge required to effectively perform their roles. Systems to monitor staff competencies are effective in ensuring staff have the required knowledge to perform their roles on an ongoing basis, and ensuring all staff have completed required competencies.
* Requirement 7(3)(e) – the approved provider must demonstrate a system implemented to ensure the regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Requirement 8(3)(a) – the approved provider must demonstrate consumers are actively engaged and supported in the development, delivery and evaluation of care and services.
* Requirement 8(3)(c) – the approved provider must demonstrate the organisation wide governance systems implemented at the service are effective. This includes in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.
* Requirement 8(3)(d) – the approved provider must demonstrate risk management systems are consistently effective in identifying and managing high impact or high prevalence risks associated with the care of consumers, responding to the abuse and neglect of consumers, and managing and preventing incidents, including the use of an incident management system. Incidents reportable under the serious incident response scheme are identified and responded to appropriately in a timely manner.
* Requirement 8(3)(e) – the approved provider must demonstrate the clinical governance framework implemented at the service is effective in ensuring safe and quality clinical care for consumers, the minimisation of restrictive practices, and antimicrobial stewardship and open disclosure principles are consistently applied.
* The service has implemented all continuous improvement actions identified in their response to the Review Audit report.

# 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. | Not Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Not Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

This Quality Standard has been assessed as not compliant as two of the six specific Requirements are not compliant.

The Assessment Team found in relation to Requirement 1(3)(a), some consumers said they have been treated with dignity and respect and their care and services aligned to their identity, culture and diversity. However, other consumers and their representatives said they were not receiving care and services consistently aligned to what is important for them, and their care was not dignified and respectful. For example, several consumers and representatives identified that inadequate personal hygiene care and staff practices regarding continence care was negatively impacting on consumer dignity. Observations by the Assessment Team demonstrated consumers were not consistently treated with dignity and respect. Care documentation showed staff and management do not always use respectful terminology when writing about consumers in care documentation.

The Assessment Team found in relation to Requirement 1(3)(c) consumers confirmed they were able to make connections with others and maintain relationships of choice. However, some consumer and representative feedback, and care documentation reviewed, indicated consumers and their representatives are not always supported to exercise choice in relation to care decisions. Consumers and representatives interviewed did not feel their choices regarding meals and mobility assistance were supported by the service. Documentation reviewed showed inconsistencies in documentation and staff practice to support consumer choice about when others should be involved and consulted about their care and services.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team.The approved provider supplied a revised plan for continuous improvement (PCI) with actions planned to address the key issues identified in the Review Audit report. This included staff training on privacy, dignity and respect and person-centred and dementia-friendly terminology, risk assessments to be reviewed for all consumers, and further mentoring and support for registered nurses.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard, as demonstrated by the actions outlined in the updated PCI. However, I consider it will take time for the improvements to be embedded and sustained in practice to ensure consumers are treated with dignity and respect, are supported to exercise choice and independence, and can maintain their identity while living the life they choose.

I find Requirement 1(3)(a) and Requirement 1(3)(c) are not compliant.

The Assessment Team found in relation to Requirement 1(3)(d), consumers interviewed felt supported to take risks and make choices about how they live their best life. The organisation had policies and procedures to provide staff with guidance on assessing and balancing choice and independence with the organisation’s duty of care to the consumer. However, for some consumers, the service had not completed risk assessment documentation to ensure informed consent and minimise risks associated with their activities of choice. During the Review Audit service management acknowledged the gaps in documentation and commenced reviewing consumer risk assessments. This was confirmed in the provider’s response to the Review Audit report. While risks associated consumer’s activities of choice were not always assessed in line with the organisation’s policies, I have considered this in my assessment of Requirement 2(3)(a). I am satisfied that for consumers sampled they were being supported to take risks to live their best life, and for most consumers these risks had been identified with some mitigation strategies in place. Considering there was no negative feedback or impact to consumers as a result of gaps in documentation I find Requirement 1(3)(d) is compliant.

The Assessment Team found in relation to Requirement 1(3)(b) consumer feedback confirmed the service provides them with culturally safe care. One consumer advised the Assessment Team they liked to be part of many activities at the service and staff know their needs and preferences well. Another consumer said they liked to attend the Catholic church service and they enjoyed going on outings to the garden centre and to the countryside as it reminded them of their life on the farm. Staff interviewed were able to describe the cultural care needs of sampled consumers.

The Assessment Team found in relation to Requirement 1(3)(e) most sampled consumers and representatives confirmed they receive and can access timely and clear information. Staff described examples of how information is provided to consumers and representatives. The service environment demonstrated consumers are given regular information regarding activities and special events through calendars in small and large print versions. Resident and relative meeting minutes and agendas showed information is regularly provided to consumers and representatives around food and catering, activities, support services and allied health, housekeeping, maintenance and continuous improvement. A representative confirmed they received an electronic tablet to assist with language translation.

The Assessment Team found in relation to Requirement 1(3)(f), consumers and their representatives confirmed they were satisfied their personal information was kept confidential and their privacy respected. Observations of the service environment showed staff observed the privacy of consumers most of the time when delivering care and services. However, the Assessment Team observed instances when consumers’ personal information was visible in common areas or not kept securely. During the Review Audit management acknowledged consumer information was visible and could be accessed by third parties. Management sent a memorandum to all staff immediately reminding them of the privacy requirements under the organisation’s policy. Management stated they were checking every hour during the Review Audit to ensure documents were locked and out of sight and computer screens were logged off after use. Management created a new PCI entry in relation to secure storage of consumer documentation at nurse’s stations.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team.The approved provider supplied a revised PCI with actions that addressed the key issues identified including training on privacy and dignity, an environmental audit and review of all workstations to ensure that privacy is protected, implementation of a nurse’s station cleaning schedule, and re-issuing of the privacy and confidentiality form for all staff to sign. The approved provider has reviewed the computer system to automatically log out after periods of inactivity, and privacy and dignity is discussed at staff meetings as standard agenda item.

I acknowledge the issues raised by the Assessment Team in relation to Requirement 1(3)(f). However, I consider the approved provider’s commitment and comprehensive actions taken both during and following the Review Audit demonstrate compliance in this Requirement.

I find Requirement 1(3)(b), Requirement 1(3)(d) Requirement 1(3)(e) and Requirement 1(3)(f) compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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. | Not Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

This Quality Standard has been assessed as not compliant as five of the five specific Requirements are not compliant.

The Assessment Team found in relation to Requirement 2(3)(a) that overall, the service did not demonstrate assessment and planning, and consideration of risks to consumer’s health and wellbeing, informs the delivery of safe and effective care and services. Care documentation showed consumer assessments were not always completed in a timely manner or by the specified role responsible. Assessments to identify risks were not completed as per the service’s policy, and they did not consistently reflect assessed risks to consumers such as aggressive behaviours in behaviour support plans (BSP), skin integrity, wounds and pressure injuries, medication administration and restraint review. Psychotropic medication and associated risks were not included in BSPs, and risks associated with recent incidents of aggression were not considered in some BSPs. Related risks associated with administration of a psychotropic medication and use of environmental restraint for one consumer were not documented in their BSP. The service’s PCI demonstrated the service had commenced some actions to improve care planning, however they were in progress.

The Assessment Team found in relation to Requirement 2(3)(b) that overall, the service did not demonstrate assessment and planning identifies and addresses consumers’ current needs, goals and preferences, including their advanced care and end of life planning if the consumer chooses. Review of care and service records, interviews with consumers, their representatives and staff, and observations showed there were deficits in several areas. Pain management needs for consumers with chronic pain were not regularly monitored and reviewed. Consumers’ BSPs were not updated when incidents of changed behaviour and aggression occurred. Details of current palliative status for consumers on a palliative care trajectory were not reflected in their advanced care plan to address their current needs goals and preferences.

One representative advised the Assessment Team they believed their consumer was approaching end of life and said the service had not had a conversation with them regarding the consumer’s care needs. Another consumer advised the Assessment Team they were not satisfied with the management of their pain. Both consumers were followed-up by management during the Review Audit

The Assessment Team found in relation to Requirement 2(3)(c) the service did not demonstrate assessment and planning is based on an ongoing partnership with consumers and representatives. While assessment and planning documentation showed input from other providers of care and services, recommendations and assessments were not always followed up by staff, such as weight monitoring requested by the medical officer of one consumer.

Interviews with consumers and their representatives indicated some involvement in planning and review of the consumer’s care and services. However, consumers or their representatives were not satisfied they were partners in care planning. The service did not demonstrate consideration or follow up of care preferences and choices when raised by consumers or representatives. Case conferences with consumers and representatives were not always arranged in a timely manner to review consumers’ care needs when their condition deteriorated. One representative said the risks associated with their consumer’s psychotropic medication have not been explained to them, and they had not attended a case conference.

The Assessment Team found in relation to Requirement 2(3)(d) the service did not demonstrate assessment and planning outcomes are effectively communicated to the consumer and documented in a care and services plan that they can access, and where care and services are provided. While some consumers and representatives had been offered a copy of their consumer’s care plan and discussed this with staff, other consumers and representatives were not aware of their care plan and had not been offered a copy. Care plans were available to staff where care and services are provided. However, information from assessment and planning was not always available and updated and some staff were not aware of information in the care plans.

The service was previously found not compliant in Requirement 2(3)(e) following a Site Audit conducted 14 – 16 June 2022. During the Review Audit the Assessment Team found while some progress has been made, this has not been sufficient or timely to bring about the improvements required, and consumer care and services are not being reviewed to ensure safe and quality care and services. Consumer care and service records showed that while some consumer care evaluations are completed, they do not always occur when consumers’ condition deteriorates, changes, and when incidents occur impacting care needs. They are not always effective for sampled consumers in areas such as pain management and when changed behaviours occur. Incident reports for behavioural, skin injury and medication incidents showed a lack of investigation to identify incident causes, triggers and prevention strategies that could be incorporated in care plans, and some incident reports remained open and in progress.

Consumer feedback was that some incidents they reported to staff were not escalated to management in a timely manner. One representative advised their consumer reported to staff three times about being assaulted by a consumer who further threatened them, but the consumer felt they were not taken seriously, and no action was taken. The representative said there had been further aggressive incidents by the consumer.

During the Review Audit, management responded to the Assessment Team’s feedback and updated their PCI. Management provided evidence that some individual consumers were followed-up including updated BSPs and incident reports being created. Documentary evidence of a memorandum sent to staff was provided that reminded them to escalate concerns regarding consumers to registered nurses or management immediately in addition to noting them in progress notes and behavioural charts. Management provided attendance records for education sessions delivered during the Review Audit, and advised screening for serious incidents had occurred and notification to the serious incident response scheme (SIRS) would be made.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team.The approved provider supplied a revised PCI with actions that addressed the key issues identified by the Assessment Team. This included staff training, review all PRN (as required) medications, develop a care plan tracker to track review of assessments and care plans, dementia practice specialist to conduct training on BSP and behaviour chart completion, education for staff on the incident management system, rand review post incident monitoring and re-assessment. The approved provider plans to complete 100% review and updating of assessments and care plans in consultation with residents and or authorised representatives, conduct case conferences per the service’s policy, audit of assessments completed to ensure timely identification; and rectifying any gaps for ongoing monitoring, and improve clinical governance of the service.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by the updated PCI and initiatives already completed. I have considered the specified completion dates in the PCI and that it will take time for the improvements to be embedded and sustained in practice to ensure the organisation works in partnership with consumers and their representatives on ongoing assessment and planning so that consumers get the services that meet their needs, goals and preferences to optimise their health and well-being.

I find all Requirements in Standard 2 are not 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)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not 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)(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. | Not Compliant |

Findings

This Quality Standard has been assessed as non-compliant as six of the seven specific Requirements are non-compliant.

The service was previously found not compliant in Requirement 3(3)(a), Requirement 3(3)(b) and Requirement 3(3)(g) following a Site Audit conducted 14-16 June 2022.

During the Review Audit, the Assessment Team found that overall, each consumer is not consistently receiving safe and effective clinical and personal care which is best practice, or tailored to their needs, and their health and wellbeing is not being optimised. Care and service documentation showed the service did not always deliver pain management medication in a timely manner as per medical officer direction, and pain charts showed ongoing pain monitoring was not always completed for some consumers with pressure injuries, infections and other conditions with a risk of pain.

Several consumers and representatives raised concern regarding pain management. A consumer said they live with chronic pain, staff are late in bringing them pain medication, and when this happens, they get anxious. Representatives interviewed noted medication stock management issues resulting in prescribed medications sometimes being out of stock when required by consumers. Review of the schedule 8 drug register showed some narcotic analgesic patches had run out of stock for days before being replaced. Some representatives interviewed provided negative feedback on personal care including inadequate hygiene and skin care, oral care, and continence care.

Care documentation showed possible triggers for behavioural escalation, such as pain and unopened bowels, were not considered before chemical restraint was used. Bedrails were used as a mechanical restraint with no information included in the consumer’s BSP. Regarding diabetes management care documentation showed there were inconsistencies in timing of blood glucose level readings and administration of medication as directed, which could negatively impact their health and wellbeing.

Regarding Requirement 3(3)(b), the Assessment Team found the service did not demonstrate high-impact, high-prevalence risks associated with the care of each consumer are effectively managed in the areas of changed behaviours, choking, falls and pressure injuries. Consumers and representatives interviewed provided mixed feedback regarding their satisfaction with the management of high impact high prevalence risks related to the care of consumers. One representative said they were not satisfise with their consumer’s care and advised their consumer has had many falls resulting in injuries. Another representative said they were worried their consumer would fall and sometimes when they visit, the consumer’s walker is in the bathroom, their call bell is on the floor and their bed sensor is not working.

The service demonstrated ineffective behaviour support resulting in gaps in risk management posed by the challenging behaviours of some consumers’ negatively impacting the health, safety and wellbeing of other consumers at the service. The service’s PCI contained actions to identify and manage risks to consumers, including some that had commenced in September 2023, including review of the high risk register and completion of file reviews for all residents identified as high risk. The PCI status was, ‘in progress.’

The Assessment Team found that overall, the service did not demonstrate consumer’s end of life needs, goals and preferences were always recognised and addressed to maximise comfort nearing end of life. Review of clinical files, interviews with staff and representatives showed for some consumers receiving palliative and end of life care, although they were provided with analgesia for pain relief, their pain management was not always optimised to prevent episodes of breakthrough pain, and there were inconsistencies in regularity and effectiveness of pain monitoring for those consumers. One representative advised the Assessment Team their consumer’s condition was deteriorating, and they did not feel the consumer would live much longer. They said they worried their consumer was in pain and staff were not doing enough to manage it. Oxygen therapy was not provided to optimise breathing comfort for one consumer nearing the end of their life. Management advised the end of life and advance care plan for one of the sampled consumers had been updated during the Review Audit. One representative of a consumer who had recently passed away at the service advised they were satisfied with the consumer’s care nearing end of life.

The Assessment Team found in relation to Requirement 3(3)(d), the service did not demonstrate for several consumers, change and deterioration in their condition was recognised and responded to in a timely manner. The service did not recognise and effectively manage escalating incidents of aggression for one sampled consumer, including consideration of mental, cognitive or physical decline and potential triggers for their behavioural deterioration. The service did not demonstrate effective and timely management of consumers following clinical deterioration including deterioration of wounds.

Several consumer representatives did not feel their consumer’s deterioration or changed condition was appropriately identified and managed. One representative advised the service did not respond appropriately to deterioration of their consumer after they had a recent fall. The representative noted the consumer was calling out in pain for 3-4 days before they were sent to hospital. The representative said since returning from hospital the consumer had declined physically and mentally and spends all their time in bed, and the representative did not feel this deterioration had been appropriately managed.

The Assessment Team found in relation to Requirement 3(3)(e) that the service did not demonstrate information about the consumers’ condition, needs and preferences was effectively communicated amongst staff. The Assessment Team observed end of shift handover between registered nurses and care staff did not always ensure transfer of required information and follow-up to meet consumers’ care and service needs. There was conflicting feedback provided by registered nurses and care staff regarding effectiveness of the handover process for morning and afternoon shifts. A care staff member advised sometimes handover does not occur and when it does, they are not always provided with sufficient information about consumers to guide care provision.

Some representatives raised concerns about poor communication between staff in relation to staff not following up and actioning requests they had made regarding consumers’ care, and concerns raised with them regarding the health safety and wellbeing of consumers. This included allegations of aggressive behaviours directed towards consumers by other consumers. Observations by the Assessment Team and interviews with staff indicated that consumer nutrition and hydration information is not communicated effectively between staff, including for consumers at risk of unplanned weight loss.

During the Review Audit the Assessment Team found there was a lack of oversight within the service in relation to management of standard and transmission-based precautions to prevent infection. The Assessment Team found guidance regarding personal protective equipment (PPE) requirements were not in line with current advice, and observed gaps in infection control measures for entry screening and during assistance in meals. For consumers in isolation due to infection-related risk, the Assessment Team identified issues regarding incorrect equipment in place to manage infection risk, staff practices in relation to isolation rooms, management of consumers in isolation rooms and assessment of their individual risks, and minimisation strategies for managing spread of infection not being observed. The Assessment Team found infection prevention and control oversight and responsibilities were not in line with current legislation and best practice to minimise risk of infection.

Clinical staff sampled and care managers understood the principles of antimicrobial stewardship but acknowledged that in practice pathology was not always taken and criteria were not always met before antibiotics were prescribed by doctors. They said they deferred to the doctors’ judgement when prescribing antibiotics and some doctors preferred to prescribe antibiotics before confirmation of infection. The Assessment Team found clinical documentation showed for some sampled consumers pathology confirmation did not occur prior to prescription of antibiotics.

The management team acknowledged and responded to the Assessment Team’s feedback during the Review Audit, including rectifying issues with PPE guidance and entry screening, education regarding antimicrobial stewardship, and enrolling staff in infection prevention and control lead training, with interim coverage arranged.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team. The approved provider supplied a revised PCI with actions that addressed the key issues identified by the Assessment Team. Identified improvements included staff education and training, engagement of an external consultant nurse practitioner to review consumers, increased clinical oversight, implementation of a surge workforce team to review consumers with identified risk and provide onsite support to local management, improved care assessment and planning, increased communication with medical officers, and improved handover processes.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by updated PCI and initiatives already completed. However, the service was previously found not compliant in Requirement 3(3)(a), Requirement 3(3)(b) and Requirement 3(3)(g), and previously identified improvements had not resulted in compliant practices across these Requirements. I have considered the specified completion dates in the PCI and that it will take time for the improvements to be embedded and evaluated to ensure they are effective in delivering safe and effective personal and clinical care that meets consumer’s needs goals and preferences and is safe and right for them.

I find Requirement 3(3)(a), Requirement 3(3)(b), Requirement 3(3)(c), Requirement 3(3)(d), Requirement 3(3)(e) and Requirement 3(3)(g) not compliant.

The Assessment Team found in relation to Requirement 3(3)(f) that timely and appropriate referrals have not been made for some consumers. Documentation showed referrals were made to the physiotherapist, podiatrist, the local palliative care team and specialist dementia services for sampled consumers. While for some consumers the Assessment Team found that referral to the consumer’s medical officer were not made in a timely manner following a change in their condition, medical officer review was arranged and undertaken during the Review Audit. The Assessment Team found that recommendations from some allied health professionals were not effectively communicated within the service or informed staff practice. However, I have considered this in my assessment of Requirement 2(3)(c) and Requirement 3(3)(e).

I acknowledge the issues raised by the Assessment Team in relation to this Requirement. However, I consider the evidence provided is more applicable to and has been addressed in other Requirements. The Assessment Team provided evidence that the service has made appropriate referrals to various allied health professionals and specialists to meet consumer needs.

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

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Not Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Not Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

This Quality Standard has been assessed as not compliant as four of the seven specific Requirements are not compliant.

The Assessment Team found in relation to Requirement 4(3)(a) that not all consumers received safe and effective supports for daily living, and this had a negative impact on their health, well-being and quality of life. Consumers who were bed bound or who required additional support to participate in activities had limited opportunities and support to participate in activities of interest. Some consumers with a BSP in place were not supported with meaningful activities to complement their behaviour support strategies and support their well-being. The Assessment Team observed that dining supports for consumers were not always meeting their needs and preferences.

The Assessment Team found in relation to Requirement 4(3)(b), consumers and representatives confirmed the religious needs of consumers were being met, and review of care documentation demonstrated there were services in place to support consumer’s religious and spiritual needs and preferences. However, services and supports for psychological and emotional support were not consistently provided for consumers who needed them. Consumer and representative feedback was that some consumers were not offered support during or after potentially traumatic or distressing events such as being subjected to or witnessing aggressive behaviours of other consumers. The Assessment Team found there was a lack of communication in relation to the management of consumers’ emotional and psychological issues, including where referral to other support services may be required.

The Assessment Team found in relation to Requirement 4(3)(d), information related to consumer’s conditions, needs and preferences for daily living was not being effectively communicated within the service to all those responsible for care. The Assessment Team found there was ineffective communication processes with catering staff regarding consumer dietary needs and preferences. This resulted in some consumers not receiving meals in line with their preferences, or dietary requirements. The service did not demonstrate processes to ensure lifestyle staff have current information regarding consumers with behaviours requiring support.

The Assessment Team found in relation to Requirement 4(3)(f) the service did not demonstrate that the meals provided were of suitable quality and quantity. Some consumers and representatives expressed satisfaction with the meals and drinks. However, others raised concerns including the meals are not well presented, the food was not tasty, the meat was tough, the portions are too small, and there was not enough food provided. Some consumers were not receiving meals in line with their dietary needs and preferences. The dining experience, including feeding support, was not optimising the dining experience and consumer well-being.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team.The approved provider supplied a revised PCI with actions that addressed the key issues identified by the Assessment Team. This included staff education and training, review of the activity program and of consumer’s lifestyle assessment documentation, improved opportunities for engagement for consumers who require additional support, engagement of a social worker to visit the service, and improved referral processes. The service has completed a review of consumer documentation regarding dietary needs and preferences and implemented new processes to communicate consumer dietary needs. The service has completed a review of the menu and dining environment to optimise consumer experience.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by the updated PCI and initiatives already completed by the service. I have considered the specified completion dates in the PCI and that it will take time for the improvements to be embedded and sustained in practice to ensure the organisation provides safe and effective services and supports for daily living that optimise consumer’s health and well-being.

I find Requirement 4(3)(a), Requirement 4(3)(b), Requirement 4(3)(d) and Requirement 4(3)(f) are not compliant.

Regarding Requirement 4(3)(c), consumer and representative feedback and documentation reviewed demonstrated consumers were participating in their community, both within the service and externally, consumers were supported to have social and personal relationships of choice, and some consumers were supported to do things of interest to them. Several consumers commented that they enjoy the bus trips arranged by the service. While some consumer’s lifestyle care documentation was inconsistent or not current, I have considered this in my assessment of Requirement 4(3)(d). While some consumers who require additional support to participate in activities were not provided this, including consumers with behaviours, I have considered this in my assessment of Requirement 4(3)(a). Considering that consumer and representative feedback was positive regarding the activities provided by the service and support to participate in the community and relationships of choice, I find Requirement 4(3)(c) is compliant.

The Assessment Team found in relation to Requirement 4(3)(e) the service demonstrated timely referrals to support consumer lifestyle needs. Care and service documentation showed appropriate and timely referrals are made to advocacy services and translation services to support daily living. A pet therapist attends the service weekly and documentation showed it is accessed by many consumers. External mobile library services have been introduced for consumers, and laughter therapy is being trialled at the service. Catholic devotions are held at the service, and musical and concerts are provided by external musicians. The Assessment Team received positive consumer feedback about the musical sessions.

The Assessment Team found in relation to Requirement 4(3)(g), equipment provided for lifestyle services is safe, suitable clean and well maintained. Consumers said they felt safe using equipment for daily living services and knew how to report any safety issues or repair needs to staff. Consumers and representatives confirmed their wheelchairs were maintained and worked well. Maintenance provided evidence of schedules for high use items, including catering and cleaning trolleys, to ensure wheels, handles and brakes are maintained, clean and in good working order. They said consumer equipment maintenance is tracked through the maintenance request system. During the Review Audit, the service established a continuous improvement action to develop a proactive maintenance schedule to review consumer owned equipment. Laundry and cleaning equipment were observed to be clean and well maintained.

I find Requirement 4(3)(c), Requirement 4(3)(e) and Requirement 4(3)(g) compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not Compliant |

Findings

This Quality Standard has been assessed as not compliant as one of the three specific Requirements are not compliant.

The Assessment Team found in relation to Requirement 5(3)(c) that although maintenance staff demonstrated some evidence of preventative and as required maintenance for furniture, fittings and equipment, this was not effective to ensure all consumer equipment was well maintained. Not all consumers had access to well maintained equipment relevant to their care needs including suitable chairs, pressure relieving equipment and beds. The Assessment Team observed some consumer furniture and equipment including lounges, chairs cabinets, and mobility equipment was dirty.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team.The approved provider supplied a revised PCI with actions that addressed the key issues identified by the Assessment Team. This included improvement cleaning and maintenance processes, increased monitoring and auditing, review of consumer equipment requirements, development of an equipment register, sourcing of new and fit for purpose equipment, and training competencies to be completed with staff.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by the updated PCI and initiatives already completed by the service. The provider’s PCI identifies that most improvements will be completed by the end of February 2024. I have considered the specified completion dates and that it will take time to ensure improvements are effective to identify and actions risks to the safety, cleanliness and maintenance of furniture, fittings and equipment.

I find Requirement 5(3)(c) is not compliant.

The Assessment Team found the service environment was welcoming, easy to understand, and fosters a sense of belonging for consumers, visitors and staff. Consumers and representatives confirmed consumers felt at home and they belonged at the service. The Assessment Team found the service and its environment support consumers to function as independently as possible. The Assessment Team observed consumer rooms were personalised with photographs, furniture and other personal items of meaning to each consumer and were representative of their personal culture and identity. Multiple private and intimate seating areas were observed throughout the service. Sensory and cognitive aids were available for consumers to enable independence and function.

The service was previously found not compliant in Requirement 5(3)(b) following a Site Audit conducted 14 – 16 June 2022. During the Review Audit the Assessment Team found, preventive maintenance of the service environment was well managed. Consumers interviewed said they were able to move freely indoors and outdoors within the service environment, and this was confirmed by observations by the Assessment Team. The Assessment Team identified some risks associated with the service environment including accessible chemicals and poor equipment storage. However, these risks were rectified during the Review Audit by the service. Some consumer feedback and observations by the Assessment Team indicated consumer rooms were not always clean.

During the Review Audit, the service acknowledged issues raised relating to cleanliness and environmental risks and demonstrated some of these had been identified as an area for improvement prior to the Review Audit. Several issues were rectified during the Review Audit and the provider’s response to the Review Audit report demonstrates planned action to rectify and monitor remaining issues.

The service demonstrated processes prior to the Review Audit to identify risks and areas for improvement to the service environment. While action taken in response had not always been effective, I am satisfied the service had completed or commenced action to rectify issues identified with the safety and cleanliness of the service environment during the Review Audit.

I find Requirement 5(3)(a) and Requirement 5(3)(b) 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. | Not Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

This Quality Standard has been assessed as not compliant as three of the four specific Requirements are not compliant.

The Assessment Team found in relation to Requirement 6(3)(a), consumers and representatives are able to provide feedback and complaints via various avenues and are reminded or these avenues at resident and relative meetings. However, several consumers and representatives did not feel supported or encouraged to provide feedback and complaints. Some consumers and representatives provided feedback that staff have not listened to them or felt staff discouraged them from making complaints. Information provided by some consumers and representatives and review of the service’s feedback and complaints register showed some complaints are not being recognised, reported, and recorded as complaints by management and staff.

In relation to Requirement 6(3)(c), the Assessment Team found the service did not demonstrate appropriate action is taken and open disclosure consistently practiced in relation to many complaints. While some consumers and representatives interviewed felt their complaints and feedback had been resolved appropriately, others did not consider their complaints had been resolved. Two representatives did not feel their concerns about their consumer’s health and safety had been resolved, and indicated an open disclosure process was not applied by the service. Some complaints raised by consumers and representatives were not recorded in the service’s complaints register, and review of the complaints register does not show that actions are being completed or evaluated for effectiveness before the complaint is closed, including seeking complainant satisfaction.

In relation to Requirement 6(3)(d) while some improvements have been made in response to consumer feedback, overall feedback and complaints were not effectively reviewed by the service and do not inform sustainable improvements in the quality of care and services. Some consumers and representatives interviewed advised they thought their complaints had been resolved but they have since found the issues have recurred. Some complaints have not been recorded in the service’s system, which means trends cannot be analysed and the need for systemic improvements identified and actioned. The evaluation of complaint outcomes has not occurred in many cases to evidence that improvements have been made to care and services. However, service management were able to identify some improvements made as a result of feedback including planned changes to the dining experience, and the purchase of a new bus.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team.The approved provider supplied a revised PCI with actions that addressed the key issues identified by the Assessment Team. This includes improved communication regarding feedback and complaint mechanisms, staff training, review of feedback and complaints to identify opportunities for improvement, and establishing timeframes for response to feedback at the service.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by the updated PCI and initiatives already completed. However, I consider it will take time for the improvements to be embedded and sustained in practice to ensure consumers feel safe and are encouraged and supported to give feedback and make complaints, they are engaged in addressing them, appropriate action is taken in response, and feedback and complaints are used to inform continuous improvements for consumers and the organisation.

I find Requirement 6(3)(a), Requirement 6(3)(c) and Requirement 6(3)(d) are not compliant.

The Assessment Team found in relation to Requirement 6(3)(b) the service is promoting advocacy services, language services and the Commission’s aged care complaints functions to consumers and representatives. Advocacy service representatives have visited the service to promote their services and information about consumer advocacy services is displayed throughout the service. Multilingual brochures are available throughout the service explaining avenues consumers can pursue to make complaints. Consumers and representatives interviewed were generally not aware of advocacy and language services or external complaint avenues, but they confirmed they were able to access information if required.

I find Requirement 6(3)(b) 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. | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not 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. | Not 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. | Not Compliant |

Findings

This Quality Standard has been assessed as not compliant as four of the five specific Requirements are not compliant.

The Assessment Team found in relation to Requirement 7(3)(a) that the workforce planned and deployed at the service was not enabling the delivery of safe and effective care and services. Some consumers and representatives did not feel there was sufficient staff to provide care and services in line with consumer’s needs and preferences and identified some negative impacts to consumer health and well-being as a result. For example, consumers or representatives identified long wait times to be assisted with continence care or transfers, and issues with supervision of consumers to ensure their safety. One consumer said they are not supported to get up and ready in line with their preferences and as a result they miss morning activities they want to participate in. While the service demonstrate workforce planning is occurring, this was not demonstrated to be effective to ensure all shifts were filled and consumers were receiving safe and quality care.

In relation to Requirement 7(3)(b) the service did not demonstrate that staff treat all consumers with kindness and respect. Some consumers said staff are kind, caring and respectful. However, feedback provided by other consumers and representatives, documentation reviewed, and observations by the Assessment Team showed this was not consistent. Examples noted by consumers included staff sometimes entering their room without introducing themselves and staff speaking disrespectfully to them.

The Assessment Team found in relation to Requirement 7(3)(c) that overall staff have the required qualifications for their role and the service has mandatory competency processes relevant to staff roles. However, these processes were not effective to ensure all relevant staff had completed required competencies, and some consumers and representatives interviewed did not feel staff had the required knowledge to effectively perform their roles. This included regarding falls prevention, behaviour support, and incident management. Identified non-compliance across Standards 2, 3 and 6 indicate deficiencies in staff competency and knowledge regarding care and service delivery and responding to complaints in line with organisational expectations.

In relation to Requirement 7(3)(e), the service did not demonstrate regular assessment, monitoring and review of staff performance. The service was not up to date on performance appraisals and monitoring documentation was also not current. Interviews with staff and review of related documentation confirmed that while some staff have had a performance appraisal completed recently, most have not. Interviews with management during the Review Audit, and the provider’s response to the Review Audit report, confirmed there is a plan to update the tracking document, schedule and complete staff performance appraisals, and to embed the regular annual cycle of performance appraisals.

The approved provider responded to the Review Audit report and acknowledged the concerns raised by the Assessment Team. The approved provider supplied a revised PCI with actions that addressed the key issues identified in the Review Audit report. Regarding the planning and deployment of the workforce this included review of the clinical staffing model, development of a roster model, review of staff numbers and mix across the service, and increased oversight of recruitment and retention. Regarding staff competency and monitoring of performance the PCI identifies the development of a new appraisal tool with a focus on professional development, review of position descriptions and competency assessment completion, and a documented training plan developed to address gaps in skills, knowledge, and competence.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by the updated PCI and initiatives already completed. I have considered the planned completion dates outlined in the service’s PCI, and that it will take time for the improvements to be embedded and evaluated to ensure they are effective in ensuring and supporting a sufficient, skilled and competent workforce.

I find Requirement 7(3)(a), Requirement 7(3)(b), Requirement 7(3)(c), and Requirement 7(3)(e) are not compliant.

The Assessment Team found in relation to Requirement 7(3)(d) that organisational recruitment and orientation processes were generally followed by the service. While some local induction documentation was not sighted by the Assessment Team, staff interviewed confirmed this had occurred. Management interviewed outlined the approach to staff training, including the planning and delivery of mandatory and other training. Management explained how attendance at training is recorded and monitored, and spoke discussed the organisation’s registered nurse graduate and development programs. The service had commenced a focus on increasing staff completion of mandatory training prior to the Review Audit. Most staff interviewed thought they had access to training relevant to their role and that there is enough training.

The provider’s response to the Review Audit report demonstrates that 90% of staff have completed the required mandatory training, and a comprehensive education and training plan has been commenced to equip and support the workforce to deliver the outcomes of the Quality Standards. While identified non-compliance across Standards 2, 3 and 6 indicate deficiencies in staff competency and knowledge, I have considered this in my assessment of Requirement 7(3)(c). The service has effective recruitment and orientation processes to support staff, had commenced improvements to the training program prior to the Review Audit, and has continued action to equip and support the workforce to deliver the outcomes of the Quality Standards.

I find Requirement 7(3)(d) is 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. | Not 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 |
| 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. | Not Compliant |

Findings

This Quality Standard has been assessed as not compliant as four of the five specific Requirements are not compliant.

In relation to Requirement 8(3)(a), the service did not demonstrate consumers are engaged in the development, delivery and evaluation of care and services. The organisational processes to analyse and incorporate consumer feedback and complaints into the development and delivery of care were ineffective and not reflective of consumer engagement. There are plans to introduce an organisational consumer advisory body and some organisation-wide improvements are in progress in response to consumer feedback and complaints. However, overall it was not demonstrated that consumers are engaged in the development, delivery and evaluation of care and services. The organisational processes regarding this have not been implemented effectively at the service.

The service was previously found not compliant in Requirement 8(3)(c) following a Site Audit conducted 14 – 16 June 2022. At the Review Audit the Assessment Team found organisation-wide systems relating to information management, continuous improvement, feedback and complaints, workforce governance, and regulatory compliance have not been effectively implemented at the service. Policies and procedures have not been implemented and some are past their due date for review. Meetings have not been held when due and communication processes and channels have not been effective to ensure information is shared within the service to support safe and quality care for consumers.

Quality audits are conducted to identify areas for continuous improvement across the Quality Standards. However, the PCI initially reviewed by the Assessment Team showed minimal progress made towards many entries and did not capture the range of improvements needed to meet the Quality Standards. The PCI was updated during the Review Audit in response to the Assessment Team’s feedback. There is ineffective governance oversight and direction in relation to workforce challenges at the service, which is evidenced in Standard 7. Governance of regulatory compliance at the service is ineffective, evidenced by the lack of an infection prevention and control lead for recent months and BSPs that do not meet regulatory requirements with restrictive practices not used as a last resort. Governance of feedback and complaints was not effective as the trend data reviewed by the governing body is incomplete and inaccurate.

In relation to Requirement 8(3)(d), the service did not demonstrate effective risk management systems and practices. The organisation has a documented risk management framework, maintains an organisational risk register, and regularly reviews the risk controls and ratings. The organisation has a system for reporting on risk to the governing body. However, risk management systems and processes have not been effectively implemented at the service level. The service was not effectively identifying and managing the high impact and high prevalence risks associated with consumer’s care. The service did not identify and respond appropriately to potential abuse and aggression between consumers, including to prevent further incidents. The service’s incident management system was not effectively identifying, reporting, managing and preventing incidents. However, the organisation recently commissioned a third-party audit regarding incident management to identify areas for improvement.

In relation to Requirement 8(3)(e), the organisation has a clinical governance framework, and a chief clinical officer was recently employed to implement the framework. There is a reporting system to enable the governing body to oversee and provide direction on the organisation’s clinical management. However, the clinical governance framework has not been effectively implemented at the service level to ensure the delivery and oversight of safe and quality clinical care. Personal and clinical care policies and procedures were not followed by staff to ensure consistent practice. While some audits had identified areas for improvement regarding clinical care and clinical governance meeting minutes show an awareness of the results of these audits, overall, there was a lack of timely action in response to the identified gaps prior to the Review Audit. Regarding minimising the use of restraint, the Assessment Team found the service’s PCI and reports to the governing body did not reflect that for chemical restraint is not being used as a last resort for some consumers in line with legislative requirements. The service did not demonstrate effective processes to ensure antimicrobial stewardship and open disclosure principles are consistently applied, and organisational monitoring had not identified or rectified this inconsistent practice.

The provider’s response acknowledged the concerns raised in the Review Audit report and included a revised PCI with actions that addressed the key issues. This included action to increase consumer engagement in the development and delivery of care and services and ensure consumer feedback is captured and used to inform service improvements. The service plans to increase staff awareness of policies and procedures and implement monitoring processes to ensure compliance, and review restrictive practice processes and use at the service. The organisation has provided additional organisational support personnel to the service. The progress of quality improvement is to be driven by the PCI and is monitored in the clinical governance meeting as a standing agenda item.

I acknowledge the commitment of the approved provider to address the issues raised by the Assessment Team in relation to this Standard as demonstrated by the updated PCI and organisational support already provided to the service. However, considering the completion dates outlined in the service’s PCI it will take time for improvements to be implemented and evaluated to ensure they are effective in ensuring the governing body’s systems are implemented at the service to ensure safe and quality care for consumers.

I find Requirement 8(3)(a), Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e) are not compliant.

The Assessment Team found in relation to Requirement 8(3)(b) the governing body has set expectations and communicated them to management and staff in relation to safe, inclusive and quality care and services through a strong governance framework. This includes policies and procedures, staff education and a team of specialist support personnel to provide support in areas including quality improvement and education. A suite of reports is provided to the governing body with information about safe, inclusive and quality care and services. These are tabled and considered at board meetings and sub-committee meetings. The Assessment Team reviewed some of the recent reports and meeting minutes confirming they include information about safe, inclusive and quality care and services. The governing body has audit programs to monitor compliance with organisational policies and procedures and to identify opportunities for improvement and innovation. Improvement action plans are developed and overseen by the executive management team and board of directors. However, the Assessment Team found the organisation policies and procedures have not consistently been followed by staff, including to ensure accurate reporting to the governing body.

The provider’s response to the Review Audit report demonstrates the commitment from the governing body to take accountability and rectify issues identified at the Review Audit, and promote a culture of safe, inclusive and quality care and services. The provider’s updated PCI includes action to ensure the organisation’s policies and procedures are followed by staff, including ongoing monitoring action. I have considered the ineffective implementation of organisation-wide policies and procedures in my assessment of Requirement 8(3)(c). Overall, I am satisfied that the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

I find Requirement 8(3)(b) is compliant.

1. The preparation of the performance report is in accordance with section 76A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)