Performance

Report

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| Name of service: | Kanandah Hostel |
| Service address: | 21 Douro Street MUDGEE NSW 2850 |
| Commission ID: | 0464 |
| Approved provider: | Kanandah Retirement Ltd |
| Activity type: | Site Audit |
| Activity date: | 6 December 2022 to 8 December 2022 |
| Performance report date: | 19 January 2023 |

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

**This performance report**

This performance report for Kanandah Hostel (**the service**) has been prepared by G. Hope-Simpson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site 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.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and representatives said they were treated with dignity and respect. Staff described what was important for consumers and explained how they promoted consumers’ dignity and respect. Care plans reflected consumers’ identity and preferences. Staff were observed attending to individual choices and communicating with consumers respectfully.

Consumers and representatives said their cultural background was recognised and respected by the service. Staff demonstrated an understanding of consumer’s identity, background, and individual values. Care plans included planning and assessments which captured consumer’s cultural needs.

Consumers said they were supported by the service to make choices, maintain relationships of choice and involve who they want in their care. Staff provided practical examples of how they assisted consumers to exercise choice and independence. Care planning documentation evidenced changes to care delivery based on consumer’s choice. Consumers were observed spending time with each other and their visitors.

Consumers and representatives said the service supported them to make decisions which involved risks. Staff described risks taken by consumers, and explained steps taken to mitigate risks identified. Care plans showed risk assessments were completed, with risk mitigation strategies documented. Staff were guided by a policy for dignity of risk.

Consumers and representatives said communication received was timely, clear, and easy to understand. Staff described different avenues used by the service to communicate information. Newsletters, activities calendars and menus were observed to be printed and available for consumers.

Consumers said their privacy was respected at all times and their doors were closed when they received care. Staff described how they kept consumers’ information confidential and maintained their personal privacy. Nurses’ stations were locked when left unattended, and all computers were password protected.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Following a previous Site Audit in April 2021, the service was found non-compliant with Requirement 2(3)(a), Requirement 2(3)(b), Requirement 2(3)(d) and Requirement 2(3)(e). Evidence in the Site Audit report dated 6 December 2022 to 8 December 2022 supports the service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

The service implemented a new suite of policies and procedures on an online platform, weekly staff workshops were delivered to amend policies in line with best practice, clinical quality officers were recruited to complete assessments and planning in line with the service’s policies and consultations were held with consumers and representatives for developing care planning documentation. Consumers and representatives said they were happy with management of identified risks for the consumers. Staff identified consumer risks and described interventions in line with care planning documentation. Care planning documentation evidenced a range of assessments being completed on entry and on an ongoing basis.

A procedure for palliative care was developed to guide staff and an internal audit was conducted to identify consumers with no advance care directives. Following this audit, 97% of consumers had an advance care directive with their end of life wishes captured in their care planning documentation. Consumers said they were consulted in relation to the needs, goals and preferences of their care, including advance care and end of life planning. Staff described how they approached advance care planning conversations with consumers and representatives. Care planning documentation reflected consumers’ current needs, goals and preferences and advance care planning.

Assessment and planning discussions with consumers and representatives were recorded in the service’s electronic care management system, with copies of care plans provided. A new form which captured input by consumers and representatives during assessment and planning was signed and filed within the electronic care management system. Consumers and representatives confirmed they received a copy of their care plan and verbal updates as changes occurred. Staff advised the outcomes of assessments were recorded in care planning documentation with updates made during handover. Care plans reflected the delivery of individualised care and regular communication with consumers and representatives about outcomes.

Procedures and forms for reviewing consumers returning to the service and post fall protocols were reviewed and redeveloped. An electronic incident management system was implemented to report, investigate, analyse, and implement actions. Consumers and representatives said they were regularly informed when consumers’ care changed and when incidents occurred. Staff said, and care planning documentation confirmed, care plans were reviewed every 3 months, when consumer’s needs or condition changed, or an incident triggered a reassessment.

Consumers and representatives confirmed their involvement in assessment and care planning through case conferences and verbal updates. Staff described the involvement of medical officers and allied health professionals in consumers’ assessment and care planning upon admission, reviews every 3 months or as requested. Care planning documentation evidenced involvement and input from consumers, representatives, medical officers, and allied health professionals in assessment and planning.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Following a previous Site Audit in April 2021, the service was found non-compliant with Requirement 3(3)(a), Requirement 3(3)(b), Requirement 3(3)(d), Requirement 3(3)(e), Requirement 3(3)(f) and Requirement 3(3)(g). Evidence in the Site Audit report dated 6 December 2022 to 8 December 2022 supports the service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

The service implemented a new suite of policies and procedures on an online platform, weekly staff workshops were delivered to amend policies in line with best practice, behaviour support plans and restraint authorisation consents were mostly completed and consumers with weight loss were identified and referred to dietitians. Consumers and representatives said their personal and clinical care needs were met. Staff described, and observations showed, consumer’s care delivered in line with care planning documentation. Care plans reflected individualised care tailored to consumer’s specific needs and preferences, informed consent for use of restraints and evidence of non-pharmacological interventions used. Some gaps in documentation of wound care were identified, with no identified impact to consumers.

Procedures and forms for reviewing consumers returning to the service and post fall protocols were reviewed and redeveloped. An electronic incident management system was implemented to report, investigate, analyse, and implement actions. Consumers and representatives said they were happy with the management of high impact or high prevalence risks. Staff described risks and related management for individual consumers. Care planning documentation showed high impact or high prevalence risks were identified, investigated and effectively managed by the service. Various equipment such as pressure relieving devices were used to manage risks.

The policies and procedures for delirium and deterioration were reviewed and developed by the service. Assessments and 3 monthly care plan reviews included general observations such as vital signs and consultations with representatives. Consumers and representatives said the service was responsive to deterioration in consumer's condition. Staff explained, and care planning documentation confirmed, the identification of and response to deterioration or changes in condition in line with the service’s policies and procedures.

Pain assessment procedures were revised to ensure more frequent pain assessments were undertaken which was confirmed by review of care plans. Care planning documentation was accessible by others where responsibility for care was shared, to provide adequate information. Consumers said their care needs, and preferences were effectively communicated between staff. Staff described how information was communicated via handovers and the electronic care management system. Care plans reflected communication with allied health professionals, medical officers and specialists when there were changes in care delivery.

Referrals were made to various external organisations, specialists and health professionals and they remain ongoing or as required. Consumers and representatives said referrals were timely, and appropriate, and they had access to relevant external health supports and services. Staff described the referrals process and how this informed care and services provided to consumers. Care planning documentation evidenced referrals to other health care providers as needed.

Education on antimicrobial stewardship was delivered to all staff and monthly infection statistics were reported to the Board. Consumers and representatives said staff performed standard and transmission-based precautions to prevent and control infection. Staff were guided by policies for antimicrobial stewardship, infection control and outbreak management. Records confirmed the majority of consumers and staff have received their COVID-19 and influenza vaccinations. Observations showed COVID-19 screening processes and staff following personal protective equipment guidelines.

Consumers and representatives said they have completed advance care directives with their end of life wishes and preferences included. Staff described practical ways in which consumers’ comfort was maximised and their dignity preserved. Care planning documentation evidenced advance care planning and consumer’s end of life wishes had been recorded. Staff were guided by policies and procedures for palliative and end of life care.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers and representatives said the services and support provided met their needs, goals, and preferences. Staff demonstrated an understanding of what was important to consumers and what they liked to do. Care plans included information required to optimise consumer’s quality of life and independence. Consumers were engaged with various activities throughout the Site Audit.

Consumers said they have received emotional, spiritual, and psychological support from the service. Staff explained various programs available which supported consumers’ well-being, including religious services. Care planning documentation reflected individualised ways staff could support consumers’ emotional, spiritual or psychological well-being. Observations showed staff spending one-on-one time with consumers and details of spiritual services displayed.

Consumers said they had social and personal relationships and engaged in activities of interest. Staff explained how activities were tailored to meet consumer’s needs and preferences. Care planning documentation reflected how consumers participated in the community and maintained connections with their loved ones. Observations showed consumers gardening and playing games throughout the service.

Consumers and representatives said their needs and preferences were well communicated. Staff said they were kept informed of changes in care and services through handovers. Care planning documentation captured contemporaneous information for staff and others involved in consumers’ care.

Consumers said referrals were timely and appropriate. Staff described how they made referrals to external services. Staff were guided by a referrals policy and procedure. Care plans evidenced collaboration between external providers to support consumers’ diverse needs. Observations showed a hairdresser attending to consumers during the Site Audit.

Consumers were satisfied with the quality, quantity and variety of meals provided. Staff explained how consumers were offered alternative meals, fresh fruit and sandwiches upon request. All tables were set with placemats, cutlery, and condiment baskets at each meal service, and meals were well-plated.

Consumers and representatives said equipment was safe, suitable, clean and well-maintained. Staff described maintenance and cleaning processes. Maintenance documentation demonstrated schedules and reactive maintenance issues were completed and up to date. Equipment which enabled consumers to engage in activities and daily living were observed to be suitable, clean, and well-maintained.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers said they felt at home at the service and were able to personalise their rooms. Staff described how consumers moved independently throughout the service. Consumers’ rooms were decorated with their personal belongings. Consumer rooms spacious single rooms with ensuite bathrooms.

Consumers and representatives said the service environment was comfortable, clean and well maintained. Staff described cleaning processes implemented at the service. Consumers moved freely throughout the service, including going outside for walks in the garden. Staff were guided by a policy and procedure for cleaning.

Consumers and representatives said their rooms were well-maintained, with repairs made promptly. Staff explained the preventative and reactive maintenance process. Maintenance records demonstrated ongoing monitoring and timely response to breakdowns and repairs required. Furniture used by consumers were observed to be comfortable, safe, clean, and well maintained.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives said they understood how to make a complaint and felt comfortable raising it directly with management. Staff described how they supported consumers to make a complaint. The feedback and complaints register and consumer meeting minutes evidenced feedback provided by consumers and representatives. Feedback forms and a suggestion box was observed in the service. An online platform was also used to gather feedback.

Consumers and representatives said they were aware of external avenues for complaints, advocacy and interpreter services. Staff described how they provided consumers with information to access these services. Documentation review and observations showed consumers were informed of advocacy and interpreter services. Information about external advocacy services and complaint mechanisms were displayed throughout the service.

Consumers and representatives generally confirmed when things go wrong, the service responded in a timely manner and open disclosure was practiced. Staff demonstrated an understanding of open disclosure. Staff were guided by a policy for complaints and open disclosure. The feedback and complaints register confirmed appropriate action taken in line with the service’s policies.

Following a previous Site Audit in April 2021, the service was found non-compliant with Requirement 6(3)(d). Evidence in the Site Audit report dated 6 December 2022 to 8 December 2022 supports the service has implemented improvements to address the non-compliance and is now compliant with this Requirement. An electronic system and additional processes were implemented by the service to action improvement opportunities based on complaints data analysis. Consumers and representatives stated they have seen feedback and complaints used to improve care and services. Staff and management explained all complaints were electronically recorded and reviewed by the Board to improve the care and services available for consumers. The plan for continuous improvement evidences actions taken in response to complaints.

# Standard 7

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

Findings

Following a previous Site Audit in April 2021, the service was found non-compliant with Requirement 7(3)(a), Requirement 7(3)(c), Requirement 7(3)(d) and Requirement 7(3)(e). Evidence in the Site Audit report dated 6 December 2022 to 8 December 2022 supports the service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

Additional clinical staff were recruited to ensure 24/7 coverage and a new call bell system with an in-built escalation workflow enabled effective monitoring of delayed call bell responses. Representatives said there were enough staff and the service was managed well during staff shortages. Staff described how the workforce was synchronised to meet consumer needs. Documentation review confirmed new staff were recently recruited. Call bell reports showed the majority of calls answered within 15 minutes.

The policy for nurse-initiated medication was updated to clearly establish responsibilities and a nurse educator role was introduced to increase clinical staff coverage. Consumers said staff were confident and competent in their roles. Staff completed competencies and demonstrated knowledge in relation to mandatory training modules. Registered staff had current registrations and all staff had current police checks.

The service implemented a new electronic training system which enabled staff to complete training modules required. Consumers and representatives said staff had appropriate skills and knowledge. Staff advised, and review of training records confirmed, they have received orientation education, ongoing training and felt comfortable requesting additional support. Some gaps in wound documentation were identified (as outlined previously in Standard 3) and it was noted only two registered staff had been supported to wound management training with an external provider. The service gave an undertaking to arrange further training within 6 months of the site audit.

Performance appraisals were undertaken individually with staff to provide feedback and discuss issues of concerns. Management provided practical examples of how staff performance was managed. Staff confirmed their performance was monitored through observations, competencies and discussions. Review of staff appraisal forms evidenced training arising from performance reviews.

Consumers said staff were kind, gentle and caring when providing care. Staff demonstrated an understanding of each consumer's individual needs and identity. Policies guided staff to deliver care in a respectful, kind, and person-centred manner. Staff were observed respectfully interacting with consumers and using by their preferred name.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Management described multiple avenues used by the service which engaged consumers and representatives in the development and delivery of care and services. Consumers confirmed they were involved in consultations with the service about care and services provided. Documentation review, including consumer meeting minutes, demonstrated opportunities to engage consumers was supported.

Consumers and representatives said they felt safe at the service and were informed of outcomes in relation to their care and services. Staff described board involvement in the promotion of a safe culture and inclusive services. Board meeting minutes showed how the service’s clinical indicators, plan for continuous improvement, financial reports, workforce changes and regulatory compliance updates were discussed.

Following a previous Site Audit in April 2021, the service was found non-compliant with Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e). Evidence in the Site Audit report dated 6 December 2022 to 8 December 2022 supports the service has implemented improvements to address the non-compliance and is now compliant with these Requirements.

The service recently implemented a comprehensive governance system which linked internal policies, training modules, corporate governance monitoring, incident management, external reporting obligations and feedback and complaints. All staff have received ongoing Serious Incident Response Scheme refresher training. Some gaps relating to regulatory compliance were identified, relating to a lack of regular staff meetings, lack of a clinical governance committee and medical advisory committee. The Assessment Team raised these gaps with management who advised clinical indicators were subject to review and weekly discussion between the clinical services manager and a quality officer, and steps were being taken to address other deficits. Two of 7 sampled behaviour support plans were not updated with the consumers’ chemical restraints; however the majority were in line with regulatory requirements. The Assessment Team were satisfied, on balance, the service fulfilled relevant requirements.

Since the implementation of the service’s governance systems, board members were able to engage directly with the integrated risk management framework. The system also supported workforce governance oversight and established clear lines of responsibilities for key management personnel. Staff were guided by policies to manage and respond to high-impact or high prevalence risks and incidents. Staff described the reporting process for incidents. Education records confirmed incident reporting training completed by staff.

The service recruited a nurse educator, updated the policies for antimicrobial stewardship, restrictive practices and open disclosure, engaged external providers to deliver restrictive practices training and introduced a new learning platform. Staff confirmed receiving education about the policies and were able to provide examples of its relevance to their work. Actions recorded in the complaints register demonstrated an open disclosure approach taken by the service when things go wrong. Staff demonstrated a shared understanding of the legislative requirements for restrictive practice.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)