Performance

Report

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| Name: | Lachlan Lodge |
| Commission ID: | 0328 |
| Address: | 48D Burns Street, HILLSTON, New South Wales, 2675 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 February 2024 to 7 February 2024 |
| Performance report date: | 22 April 2024 |
| Service included in this assessment: | Provider: 1165 Lachlan Lodge Inc  Service: 344 Lachlan Lodge |

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 Lachlan Lodge (**the service**) has been prepared by Kirsten Peddie, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers, representatives and others.
* the provider’s response to the assessment team’s report received 27 February 2024.
* the Performance report dated 24 March 2023 for a site audit conducted 7 February 2023 to 9 February 2023.

# Assessment summary

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| 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 applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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 2(3)(b) – the service should ensure that assessment and planning for each consumer demonstrates consideration of risks associated with the consumer’s care. Ongoing assessment and planning must occur for all consumers. All assessments and care plans must include comprehensive, up to date, accurate and complete information. Assessment and care planning must always be completed by appropriately qualified staff.
* Requirement 2(3)(c) – the service should ensure that assessment and planning identifies and addresses each consumer’s current needs goals and preferences. Behaviour support plans must be individualised specific to each consumer. There should be a clear process for assessing and documenting if a consumer is subject to environmental restrictive practices.
* Requirement 2(3)(d) – the service should ensure that the outcomes of all assessment and planning are communicated to consumers and this process is clearly understood and applied by all staff. A current, complete, and accurate care and services plan should be readily available to all consumers, and where care and services are provided.
* Requirement 2(3)(e) – the service should ensure that care and services are reviewed regularly for effectiveness. Care and services must always be reviewed when circumstances change or when incidents impact the needs goals and preferences of the consumer. The review of care and services must be undertaken by an appropriately qualified staff member.
* Requirement 3(3)(b) – the service should ensure effective management of high impact and high prevalence risks for consumers. The service must identify, review, analyse, monitor, and manage clinical incidents. The service must demonstrate an understanding of restrictive practices and ensure there is appropriate risk assessment, authorisation and informed consent completed in accordance with the Quality of Care Principles 2014.
* Requirement 3(3)(e) – the service should ensure that information about consumer’s condition, needs and preferences is complete, current, accurate and clearly documented so it can be communicated correctly within the organisation and to others where responsibility for care is shared. The service must have effective processes for the updating, communication, actioning and implementation of medical practitioner and external specialist review and directions.
* Requirement 3(3)(g) – the service should ensure all staff have an understanding of standard and transmission-based precautions. The service must assess the risk of, and take steps to prevent, detect and control the spread and severity of infections. The service must have an Infection Prevention and Control Lead who meets the requirements of the Department of Health and Aged Care for Infection Prevention and Control Leads.
* Requirement 7(3)(c) – the service must demonstrate staff are competent and have the knowledge and oversight required to effectively perform their roles. This includes identification and management of risks for consumers, clinical monitoring, and management of falls, wound care, restrictive practices, weight loss and medication management. Staff have clear responsibilities of their role and do not work outside of their scope of practice.
* Requirement 7(3)(d) – the service must demonstrate staff are trained, equipped and supported to deliver the outcomes required by the Quality Standards. The service has processes in place to identify, address and evaluate the ongoing training needs of staff.
* Requirement 8(3)(c) – the service must demonstrate the organisation wide governance systems implemented at the service are effective. This includes in relation to information management, continuous improvement, workforce governance, and regulatory compliance.
* Requirement 8(3)(d) – the service must demonstrate risk management systems are consistently effective in identifying and managing high impact or high prevalence risks associated with the care of consumers. The service has an incident management system that ensures effective monitoring, analysis and trending of incidents, and implementation of suitable risk mitigation strategies to prevent further incidents.
* Requirement 8(3)(e) – the provider must demonstrate the clinical governance framework implemented at the service ensures the oversight, monitoring, and evaluation of safe and quality clinical care for consumers. The clinical governance framework must support and provide appropriate guidance for the service to provide safe and quality clinical care including to ensure consumers subject to restrictive practices are identified appropriately, with informed consent, assessment, and behaviour support planning undertaken in line with legislative requirements.

# 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)(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

The Quality Standard is assessed as not compliant as four of the five specific Requirements have been assessed as not compliant.

The service was previously found not compliant in Requirement 2(3)(a), Requirement 2(3)(b), Requirement 2(3)(d) and Requirement 2(3)(e) following a Site Audit conducted 7 February 2023 to 9 February 2023.

At the Assessment Contact conducted 6 February 2024 to 7 February 2024, the Assessment Team found the service did not demonstrate the consideration of risk to consumer’s health and well-being is being identified through assessment and planning or managed effectively. While initial assessment and planning has been completed for consumers when they first enter the service, ongoing assessment and planning has not been consistently completed to identify individual consumer risks or updated when new risks have been identified. Consumer’s assessments and care plans are not comprehensive or up to date, lack detail to inform care and service delivery, and some include conflicting information. Assessments are not completed when due, or in a timely manner when needed, and are not always completed by appropriately qualified staff.

While the service has demonstrated some improvements in the assessment and documenting of advance care planning and end of life planning, consumers current needs goals and preferences have not been identified and addressed. Three consumers with diabetes mellitus did not have individualised assessment and planning to guide staff practice. Behaviour support plans for consumers contained generalised information, were not contemporaneous, and did not include information provided by external dementia specialists to guide care. For one consumer the service had not included current wound management directives from an external registered nurse and staff did not demonstrate awareness of the directives. The service had not identified consumers who are or may be subject to environmental restrictive practices.

The Assessment Team found that while consumers and representatives advised they were updated by the service on some matters, a lack of assessment and the resulting lack of care planning meant there were minimal outcomes of assessment and planning to communicate. As a result of these deficiencies consumers and representatives did not recall being involved in the consumer’s assessment and care planning, advised of the outcomes of assessment and planning, or offered a copy of the consumer’s care and services plan. There was also inconsistent understanding between staff of the service’s processes as to how the outcomes of the assessment and care planning process are communicated to consumers and representatives. While a copy of the care and services plan had not been consistently provided to consumers and representatives, from December 2023 service management advised they had implemented a process of documenting in progress notes when a copy of the consumers’ care and services plan had been provided. A review of care documentation confirmed this did occur for some consumers. However, due to service management being on leave for January 2024, this process was not sustained.

Most consumers and representatives who spoke with the Assessment Team advised they are kept up to date with changes relating to the consumer. However, care documentation identified the service was not able to demonstrate that care and services were reviewed regularly for effectiveness, when circumstances changed or when incidents impacted on the needs, goals and preferences of the consumers sampled. There is a lack of assessment and planning conducted and as a result care plans are incomplete and ineffective even before a consumer’s circumstances change or incidents occur. The Assessment Team identified gaps in assessment and review following a fall for a consumer. For another consumer, recommendations and directives not updated following external dementia specialist review and for another consumer following an external wound review, re-assessments being undertaken by non-clinical staff, and no review of a consumer post hospitalisation. The service does not demonstrate processes to ensure the regular monitoring, analysis and trending of incidents, and the implementation of suitable risk mitigation strategies for consumers.

Managed advised the Assessment Team there was a plan to review all consumers assessments and care plans and implement care plan reviews and case conferences, there was also a plan to ensure this will be undertaken by appropriately qualified staff.

The approved provider’s response to the Assessment Contact report accepts that a core issue at the service has been the lack of registered nurse oversight. The provider acknowledges that assessments are not well documented, the service were relying on an off-site registered nurse, and it had not been identified that assessments were not being completed as required. The provider advised all care plan reviews are now being undertaken by a registered nurse on site. The service has reviewed all behaviour support plans, however, believe that while strategies sound generic they are appropriate for the consumer. The service has updated the diabetic assessment forms for the three consumers who have diabetes mellitus. The service advised staff have received training on the need to transfer information from external providers into progress notes and update assessments. The provider advised while not all consumers have been formally assessed the staff are aware of who requires and who does not require environmental restrictive practice, and only two consumers have a restrictive practice, and the two consumer both now have a current consent. The provider advised that a review of how consumers and representatives are involved in care planning and offered a copy of their care plan is being undertaken. The consumer and representative have always been involved in the 3 monthly care review. However, all consumers will now have an annual case conference attended and the case conference process will commence once the care plan review for all consumers has been completed. The provider advised care staff have received training on basic care management in the absence of having a registered nurse, but were not aware of the need to update the care plan when an external specialist was managing wound care. A process for reviewing consumers following return from hospital has implemented. The capture of data on incidents and collation of this date has commenced but is still in its infancy, it is planned for this to occur and to be presented to the Board on a monthly basis.

While I accept the service is working towards ensuring there are effective process for ongoing assessment and planning, I am concerned that the service have not identified the deficits earlier and taken action to address these deficits given the already identified non-compliance in Standard 2 following the site audit in February 2023.

The approved provider does not demonstrate an understanding of restrictive practices and their obligations. The service does not demonstrate an understanding of environmental restrictive practices and does not demonstrate they have appropriately assessed all consumers to determine if they are subject to environmental restrictive practices. See further information in Standard 3 regarding environmental restrictive practices. While the approved provider advised consumers and representatives have always been involved in the 3 monthly care review, these reviews have not been occurring, therefore consumers and representatives have not had the opportunity to be involved. While the annual case conference process is planned, the effectiveness of this and a process to ensure that outcomes of assessment and planning at all times is communicated to consumers is yet to be demonstrated. While the approved provider advised a process for the review of consumers post-hospitalisation has been implemented, the supporting evidence only states a review must be undertaken, a return from leave checklist completed, and the on-call registered nurse to be informed. This does not demonstrate an understanding by the approved provider of the need for care and service review when circumstances change, and for the review to be undertaken by appropriately qualified staff. The monitoring, analysis and trending of incidents is not demonstrated and there is no evidence to show how this will result in the implementation of risk mitigation strategies and improved outcomes for consumers.

I was not provided sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team, these include having the systems and process to identify and address deficits in practice, review outcomes and adjust staff practice. The approved provider is still undertaking improvements and I encourage them to embed these into their usual practice to ensure all consumers are a partner in the initial and ongoing assessment and planning that focuses on optimising health and well-being in accordance with the consumer’s needs, goals, and preferences. Accordingly, I find that Requirements 2(3)(a), 2(3)(b), 2(3)(d) and 2(3)(e) are not compliant.

# Standard 3

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| Personal care and clinical care | |  |
| 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)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as three of the seven specific Requirements have been assessed as not compliant.

The service was previously found not compliant in Requirement 3(3)(b), Requirement 3(3)(e), and Requirement 3(3)(g) following a Site Audit conducted 7 February 2023 to 9 February 2023.

At the Assessment Contact conducted 6 February 2024 to 7 February 2024, the Assessment Team found while overall, consumers and their representatives expressed satisfaction with the care provided, the service was unable to demonstrate the identification, management and monitoring of risks related to the personal and clinical care of each consumer. This included the effective management of medications, wounds, restrictive practices, falls, and weight loss. Three consumers who had new or changed medication documented on their medication chart in January 2024, did not receive their required medication, including antibiotics, for respectively 7 days, 10 days, and 8 days. Wound management was being completed by care staff with inconsistent registered nurse review. A consent form for a chemical restrictive practice was signed by a non-clinical staff member and there was no evidence of risk assessment, authorisation and informed consent being completed in line with the Quality of Care Principles 2014. It was identified by the Assessment Team that there were 13 consumers who were subject to environmental restrictive practices which had not been identified by the service. Strategies to minimise consumer’s risk of falling were not consistently followed. There was not consistent understanding of potential weight loss for one consumer or the strategies to be implemented to address this. While staff could describe some risks associated with the personal and clinical care of consumers, this was not consistent and did not align with risks documented in consumers care and service plans. Care and service plans were not contemporaneous and did not consistently document strategies to mitigate risks to guide staff in care delivery. The service manages a clinical high-risk register, which included the identification of consumers risks including falls, skin integrity, weight loss, diabetes, psychotropic medication, restrictive practices, changed behaviours, pain and warfarin. However, the Assessment Team review of the clinical high-risk register, alongside individual consumers care documentation identified inconsistencies.

Management advised the Assessment Team education had been provided to staff on medication management. Care staff have been trained in wound management and this is provided by non-clinical staff members. The registered nurse has identified the need for training and competency assessment of staff in clinical tasks and this is planned to occur. The registered nurse will also be overseeing all wound management. Management advised they planned to review and assess all consumers to identify if they are subject to environmental restrictive practice, and they will consider alternative strategies to minimise the restrictive practice.

Whilst overall, consumers and their representatives expressed satisfaction with clinical and personal care and service delivery, consumers and representatives interviewed by the Assessment Team did not have any feedback about the communication amongst staff or with other health professionals about the consumer’s condition, needs and preferences. Observation by the Assessment Team shows clinical and care staff handover occurs. However, documentation reviews and staff interviews show that information is not well communicated with relevant stakeholders about the condition, needs and preferences of the consumers sampled. When asked by the Assessment Team how they know about the care needs of a consumer, care staff said they refer to the consumer’s care plan. However, review of care plans for the consumers sampled showed they do not reflect consumer’s current condition, or their care needs, goals, preferences or risks associated with their care and how to manage them. The service’s communication processes did not ensure the transfer of important information about a consumer’s care within and between organisations that are responsible for the consumer’s care and services.

The Assessment Team observed on entry to the service, visitors and contractors are subject to infection prevention and control screening. While the service has implemented an outbreak management plan with associated documents to guide staff practice, this information had not, at the time of the Assessment Contact, been shared with staff. The service has not practiced appropriate antibiotic usage with delays for three consumers in receiving their prescribed antibiotics. The service did not have an Infection Prevention and Control (IPC) Lead until the contracted registered nurse arrived at the service 2 weeks prior to the Assessment Contact. The contracted registered nurse stated they are at the service until the end of February 2024 and the service does not have another registered nurse undertake the training to be an IPC Lead. The service manager who is not a registered nurse, told the Assessment Team they and another care staff member have enrolled to complete an infection control course to become an assistant to the IPC role. Management stated they have implemented a system to monitor infections, antibiotic use and vaccinations, however, the information provided to the Assessment Team identified, vaccination information was not available, and management were unaware of the number of consumers who have received vaccinations, Management did not know the process for reporting of consumer infections at the service, however, was aware of the required isolation for consumers if unwell and showing signs and symptoms of infections. Staff interviewed by the Assessment Team said they had received education and training in handwashing and use of personal protective equipment (PPE), including donning and doffing and the registered nurse said, they would be providing updated information to staff.

The approved provider, in their response to the Assessment Contact report, advised an education schedule has been developed for 2024. There have been updates to the handover sheet to include consumer needs and risk, and daily clinical huddles have been introduced. The approved provider included evidence of medical practitioner notes for one chemical restrictive practice but no evidence for how environmental restrictive practices have been assessed and addressed. The approved provider advised they have good communication and provided evidence from the daily huddles which did not show any discussion of clinical issues and related to kitchen, laundry, cleaning and maintenance matters. The clinical handover sheet provided did make reference to medical practitioner appointments and one direction to read a dietitian’s notes.

The approved provider disputed the Assessment Team findings that the service is not minimising infection-related risks. The provider advised the outbreak management plan is available to staff and is now located in the nurses’ office. The service advised staff are aware of anti-microbial stewardship and the need to reduce overprescribing and unnecessary prescribing. All staff have completed a competency for PPE and handwashing, and infection control training, which occurred following the Assessment Contact. The provider acknowledged vaccination information is in individual files which is harder to maintain but does show a record is kept. The service has created a consolidation register of vaccination information. The approved provider advised they do record and monitor infections, and these are discussed at staff meetings, however evidence of only one meeting in 2023 was provided stating only the number of infections, and no detail of how the service is assessing the risk of, and taking steps to prevent, detect and control the spread and severity of infections. The provider’s response did not address if the service has a current IPC Lead, which is a requirement.

While I accept the service is working towards ensuring there are effective process for personal care and clinical care, I am concerned that the service have not identified the deficits earlier and taken action to address these deficits given the already identified non-compliance in Standard 3 following the site audit in February 2023.

The approved provider does not demonstrate effective processes for the assessment and identification of high impact and high prevalence risks, and therefore there is not effective management of high impact and high prevalence risks. The provider has not demonstrated management of these risks is undertaken by appropriately qualified staff. It is not evident staff at the service have accurate and complete information on high impact and high prevalence risks for consumers relevant to their role. The provider does not demonstrate an understanding of environmental restrictive practices and the service have not identified consumers who are subject to environmental restrictive practices. There is evidence that information about consumer’s conditions is not documented and communicated, and directives from external medical practitioners and specialists have not been followed. Whilst there is collection on information on infections there is no evidence to show how the service interrogates and uses data and information to monitor infections and resolution rates and the effectiveness of the infection prevention and control program. Antibiotics have not been given in a timely manner which does not support the practices of appropriate antibiotic use to support optimal care. It is not clear if the service has a current IPC Lead who meets the requirements set by the Department of Health and Aged Care for IPC Leads.

I was not provided sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team, these include having the systems and process to identify and address deficits in practice, review outcomes and adjust staff practice. The approved provider is still undertaking improvements and I encourage them to embed these into their usual practice to ensure all consumers get personal care and clinical care that is safe and right for each consumer and is in accordance with each consumer’s needs, goals and preferences to optimise health and well-being. Accordingly, I find that Requirements 3(3)(b), 3(3)(e) and 3(3)(g) are not compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

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

The service was previously found not compliant in Requirement 4(3)(f) following a Site Audit conducted 7 February 2023 to 9 February 2023.

At the Assessment Contact conducted 6 February 2024 to 7 February 2024, consumers interviewed by the Assessment Team said the meals provided by the service are varied and of suitable quality and quantity. Consumers are offered a range of meal options, including alternative meals if they choose not to eat the meals offered on the menu. Staff were aware of consumer’s nutrition and hydration needs and preferences, and regularly seek feedback on the quality of the meals provided. The service has a seasonal menu that has been reviewed by a dietitian.

I find Requirement 4(3)(f) is compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

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

The service was previously found not compliant in Requirement 6(3)(d) following a Site Audit conducted 7 February 2023 to 9 February 2023.

At the Assessment Contact conducted 6 February 2024 to 7 February 2024, consumers interviewed felt appropriate action is taken in response to their complaints, and believed they contributed to improvements in care and services. The service has regular consumer meetings where minutes are collated, and consumers interviewed spoke of attending these meetings and being able to provide feedback. The month prior to the Assessment Contact the service had implemented new processes to capture consumer feedback and had recently implemented a complaints register. However, these feedback processes and register had not yet been reviewed or analysed to inform improvements. Management and the Board provided examples of recent improvements made to the service as a result of consumer engagement and feedback. For example, recent improvements to outdoor consumer areas and meal services.

The provider’s response to the Assessment Contact report acknowledges the improvements required to the documentation and analysis of feedback and complaints and identifies plans in place to review complaint and feedback data to identify trends and inform continuous improvement. Since the Assessment Contact the service has documented the action taken, and evaluation of feedback and complaints.

Considering the provider’s response and evidence in the Assessment Contact report, I am satisfied that feedback and complaints were being used to improve the quality of care and services. The service has improved documentation and monitoring of feedback and complaints and has commenced processes to ensure these are analysed and reviewed to inform improvements.

I find Requirement 6(3)(d) is compliant.

# Standard 7

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| Human resources | |  |
| 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. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as two of the five specific Requirements have been assessed as not compliant.

The service was previously found not compliant in Requirement 7(3)(c) and Requirement 7(3)(d) following a Site Audit conducted 7 February 2023 to 9 February 2023.

At the Assessment Contact conducted 6 February 2024 to 7 February 2024, the Assessment Team found the workforce did not demonstrate the competency and knowledge to effectively perform their roles. Service documentation, interviews with staff and observations by the Assessment Team identified staff continue to undertake responsibilities outside of their scope of practice, including providing clinical guidance and making decisions about the escalation of clinical issues. The service had recently engaged additional registered nurses to assist with clinical oversight and administration of PRN (as required) Schedule 8 (S8) medications. However, when registered nurses are not onsite the service does not have qualified staff to provide PRN S8 medications. Additionally, the Assessment Team identified recent serious incidents related to medication errors made by care staff, indicating issues with knowledge and competency.

The service did not demonstrate the workforce is adequately trained, equipped, and supported to deliver the outcomes required by the Quality Standards. The service demonstrated limited training had taken place in response to previously identified non-compliance. While plans were in place for future education, training, and monitoring of staff for 2024, due to contract considerations it was unclear who would be taking responsibility for delivery and evaluation of this training. A number of critical policies and procedures were under review during the Assessment Contact and had not been reviewed by staff to inform their practice and care and service delivery. The Assessment Team found staff practice did not align with the Quality Standards regarding care assessment and planning including identification and management of risks for consumers, clinical monitoring, and management of falls, wound care, restrictive practices, weight loss and medication management.

The provider’s response to the Assessment Contact report provides additional information about clinical oversight and guidance that was available to staff during the Assessment Contact, and work the provider is doing to improve this. Since the Assessment Contact, the service has undertaken competency assessments with staff including medication administration competencies, and improved delivery and oversight of staff training.

While I accept the service is working towards ensuring effective clinical practice and oversight arrangements, the service has not yet demonstrated that the workforce is trained, equipped and supported to deliver the outcomes required by the Quality Standards. Deficiencies in staff practices regarding clinical assessment and management indicates that staff do not have the required knowledge and competency to effectively perform their roles and ensure care and services provided are in line with the Quality Standards. Action taken by the service to train and support staff requires further monitoring and evaluation to ensure it is effective in delivering the outcomes required by the Quality Standards.

I was not provided sufficient evidence in the approved provider’s response to satisfy me that the service has addressed all of the deficiencies identified by the Assessment Team. These include having the systems and processes to identify and address consumer’s concerns, review outcomes and adjust staff practice. The approved provider is still undertaking improvements and I encourage them to embed these improvements into their usual practice to ensure all consumers get quality care from a workforce that is competent with the required qualifications. Accordingly, I find Requirements 7(3)(c) and 7(3)(d) are not compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(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

The Quality Standard is assessed as not compliant as three of the five specific Requirements have been assessed as not compliant.

The service was previously found not compliant in Requirement 8(3)(a), Requirement 8(3)(c), Requirement 8(3)(d), and Requirement 8(3)(e) following a Site Audit conducted 7 February 2023 to 9 February 2023.

At the Assessment Contact conducted 6 February 2024 to 7 February 2024, the Assessment Team found the organisation did not demonstrate effective governance systems for information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints. Information management systems including care planning and assessment, and best practice policies and procedures, were not providing consistent and comprehensive information to guide staff in providing safe and effective care and services. The Assessment Team found limited evidence of consistent reporting structures from the service to the Board. While the organisation has a plan for continuous improvement, actions identified are at various stages of completion, with inconsistent understanding by staff of the improvements or plans in place to complete these actions. The Assessment Team identified some concern regarding staff wages that indicated ineffective financial governance in place at the organisation. The organisation did not demonstrate effective workforce governance to ensure staff are competent and well supported in their role, and work within their scope of practice. The regulatory compliance systems were not effective to ensure compliance with the serious incident response scheme and incident management requirements, or best practice regarding restrictive practices. The service did not demonstrate it provides ongoing education and training to staff to support compliance with legislative requirements and changes. The Assessment Team found complaints and feedback were not consistently being monitored or trended to improve the quality of care and services for consumers.

The provider’s response included additional information about the Board’s structure, including reporting structures, and policies and procedures that were being reviewed prior to distribution to staff. The provider’s response includes clarifying information about financial governance arrangements and matters that indicates while issues were identified in the past, this has been rectified with plans to support ongoing financial management. The provider had commenced action to address the deficiencies in workforce governance prior to the Assessment Contact, with work continuing. Since the Assessment Contact, a more robust complaints register has been developed to support monitoring and review of complaints and feedback.

Considering the additional and clarifying information provided in the provider’s response to the Assessment Contact report, I am satisfied the organisation has effective governance systems relating to financial governance, and feedback and complaints. However, systems for information management, regulatory compliance, and workforce governance have not been demonstrated to be effective in guiding, supporting, and monitoring of the workforce to provide safe and effective care and services for consumers. While the organisation has commenced continuous improvement in response to previous non-compliance and identified areas for improvement across the service, many of these are still underway and have not yet been evaluated to ensure they are effective in rectifying identified areas requiring improvement.

The Assessment Team found the organisation did not demonstrate effective risk management systems and practices in relation to managing high impact and high prevalence risks associated with consumer’s care and managing and preventing incidents. While the service was in the process of revising new policies and procedures, including policies to inform risk management, these policies and procedures had not been implemented at the time of the Assessment Contact. While the service maintains a clinical high-risk register, information in this register was inconsistent with consumer care documentation and the service was unable to evidence practices to ensure the identification, management and monitoring of risks associated with consumer’s care. While the service was reporting incidents through their incident management system, the service did not demonstrate processes to ensure monitoring, analysis and trending of incidents, and implementation of suitable risk mitigation strategies in response. Incidents related to medications, falls, behaviours, and wounds were not investigated to inform new strategies to prevent further incidents.

The Assessment Team found the service did not demonstrate effective clinical governance systems for delivering safe and quality clinical care and to ensure continuous improvement of care and service delivery. The Assessment Team found systems were not effective to ensure appropriate clinical oversight and guidance for staff. The clinical governance systems at the service were not effective in ensuring consumers subject to restrictive practices are identified appropriately, with informed consent, assessment, and behaviour support planning undertaken in line with legislative requirements. Clinical reporting arrangements had not informed the Board of the use of restrictive practices within the service, therefore appropriate oversight and monitoring by the Board had not occurred. Although staff demonstrated understanding of open disclosure, the service did not demonstrate they were following their policy, procedures, and framework in ensuring complainants had received an apology when appropriate.

In their response to the Assessment Contact report, the provider acknowledges that risk management systems and practices, and clinical governance, requires improvement and further support by clinical staff which the provider is working towards. The provider’s response to the Assessment Contact report provides further information regarding the service’s processes for communicating and recording incidents and plans to implement the revised policies and procedures with associated education for staff.

The organisation’s governance systems were not effective in ensuring the delivery of safe and quality care and services for consumers. Risk management systems and practices were not effectively managing risks and incidents for consumers across the service. Clinical governance arrangements were not effective in identifying, assessing, monitoring, and minimising the use of restrictive practices. While the organisation has commenced some continuous improvement in response previous non-compliance and further deficiencies identified at this Assessment Contact, significant work is still underway and requires evaluation to ensure it is effective.

I was not provided sufficient evidence in the provider’s response to satisfy me that the service has addressed all of the deficiencies identified in the Assessment Contact report. These include having the systems and processes to identify and address consumer’s concerns, review outcomes, and adjust staff practice. The approved provider is still undertaking improvements and I encourage them to embed these improvements into their usual practice in the service to ensure the service delivers safe and quality care and services that meet the Quality Standards, so consumers live in a service that is well run. Accordingly, I find Requirement 8(3)(c), Requirement 8(3)(d), and Requirement 8(3)(e) are not compliant.

The service demonstrated consumers are engaged in the development, delivery and evaluation of care and services. Management and the Board provided examples of recent consumer engagement that led to improvements to the service. For example, recent alterations to outdoor consumer areas. The Board is expanding their engagement with consumers and is encouraging volunteers to participate in the consumer advisory panel. Board members regularly visit the service and meet with consumers to discuss their care and services and use any feedback to guide changes. The service has recently reviewed and updated its feedback and complaints management policy and procedure, however, this is yet to be fully implemented by the service.

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

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