Performance

Report

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| Name of service: | Lee Roshana Care |
| Service address: | 1 Queen Street BLAYNEY NSW 2799 |
| Commission ID: | 0327 |
| Approved provider: | Burswood Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 16 May 2023 to 18 May 2023 |
| Performance report date: | 12 July 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 Lee Roshana Care (**the service**) has been prepared by M Buhagiar, 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 conducted 16 May to 18 May 2023, 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 03 July 2023. The provider responded on 3 July that their response on 12 June 2023 to the Notice to Agree issued by Compliance on 2 June 2023, was to be used for the response to the Assessment Team’s report.
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: Notice to Agree issued on 02 June 2023, following Site Audit conducted 16 May to 18 May 2023.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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)(c) The approved provider must demonstrate that robust systems are implemented to support consumers to exercise choice and independence and make decisions about who and how they wish others to be involved in their care.

Requirement 1(3)(d) The approved provider must demonstrate risks are identified for actions taken by consumers to enable them to live the best life they can and that measures are put in place to mitigate risks related to those actions.

Requirement 1(3)(f) The approved provider must demonstrate that consumer’s personal information is kept safe and confidential.

Requirement 2(3)(a) The approved provider must demonstrate that there is effective consideration of risk to consumers health and wellbeing in the assessment and planning processes to inform delivery of safe and effective care and services.

Requirement 2(3)(b) The approved provider must demonstrate that they are identifying and addressing consumers’ current needs, goals and preferences in the assessment and planning processes.

Requirement 2(3)(c) The approved provider must demonstrate assessment and planning is consistently based on partnership with consumers and includes other providers of care and services.

Requirement 2(3)(d) The approved provider must demonstrate effective communication of the outcomes of assessment and planning to consumers, and document in a care and services plan that is readily available to consumers or their chosen representatives.

Requirement 2(3)(e) The approved provider must demonstrate care and services are reviewed following changes in circumstances or when incidents occur.

Requirement 3(3)(a) The approved provider must demonstrate that staff have training to follow the services’ policies and procedures and that qualified staff are making clinical decisions and care staff do not undertake assessments outside of their scope of practice.

Requirement 3(3)(b) The approved provider must demonstrate that the service identifies high impact/high prevalence risks associated with the care of consumers though review of incidents and that all incidents are documented on incident reports and investigated to develop mitigating strategies to prevent the reoccurrence of incidents. The service must demonstrate it is taking action to reduce the high impact risk to consumers who take multiple medications.

Requirement 3(3)(c) The approved provider must demonstrate they are recognising and addressing the needs, goals and preferences of consumers nearing the end of life to maximise their comfort and preserve their dignity.

Requirement 3(3)(d) The approved provider must demonstrate changes or deterioration in consumers’ mental health, cognitive or physical function, and that their capacity or condition is recognised and responded to in a timely manner.

Requirement 3(3)(e) The approved provider must demonstrate all consumers' information including assessments and care plans from the paper-based system are entered into the electronic system accurately and it is reviewed by staff to ensure that consumers’ condition, needs and preferences are known by staff who need to know.

Requirement 3(3)(f) The approved provider must demonstrate consumers are referred to appropriate specialist services in a timely manner to improve outcomes for their health and well-being.

Requirement 3(3)(g) The approved provider must demonstrate staff undertake training on outbreak management and understand infection prevention and control and antimicrobial stewardship and demonstrate a practical knowledge of this. All records relating to vaccinations must be current and reflected in documentation.

Requirement 4(3)(d) The approved provider must demonstrate that care planning information includes consumers’ spiritual, emotional and lifestyle needs and that this information is communicated within the organisation or with others where responsibility for care is shared.

Requirement 4(3)(f) The approved provider must demonstrate that consumers have input into the menu and that meals meet consumers’ dietary needs and that information about dietary needs is understood by staff.

Requirement 5(3)(b) The approved provider must demonstrate that there is an effective maintenance schedule for the service’s environment and equipment and that preventative maintenance and reactive maintenance are scheduled and conducted.

Requirement 5(3)(c) The approved provider must demonstrate all staff have the knowledge to ensure that equipment is safe, clean and well maintained for consumers.

Requirement 6(3)(c) The approved provider must demonstrate appropriate action or investigation is undertaken in response to feedback and complaints and that open disclosure is always used when things go wrong.

Requirement 6(3)(d) The approved provider must demonstrate feedback and complaints is documented and reviewed to improve the quality of services to consumers.

Requirement 7(3)(c) The approved provider must demonstrate they provide effective human resource systems to ensure the workforce are competent and have a sound knowledge to effectively perform their roles and that all staff are working within their scope of practice.

Requirement 7(3)(d) The approved provider must demonstrate effective systems to ensure the workforce is recruited, trained, equipped and supported to effectively deliver the outcomes required by the Quality Standards. That staff who do not hold the relevant qualifications associated with their work undertake the qualifications and demonstrate competence in their roles.

Requirement 7(3)(e) The approved provider must demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken when it is identified that staff require a review of their skills and knowledge.

Requirement 8(3)(a) The approved provider must demonstrate active partnering and engagement with consumers in the development, delivery and evaluation of their care and services.

Requirement 8(3)(b) The approved provider must demonstrate there is an effective governance framework to identify and manage deficiencies with actions recorded for identified trends or measures to deliver safe, inclusive and quality care and services.

Requirement 8(3)(c) The approved provider must demonstrate that it has effective organisational systems to monitor information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints and that the organisation can demonstrate that its local governance systems feed into and are supported by the overall organisational governance framework and accountability structure.

Requirement 8(3)(d) The approved provider must demonstrate that it has an effective process for risk management which are effectively monitored; including in relation to managing high-impact or high prevalence risks, support for consumers to live the best life they can and managing and preventing incidents. In addition, staff have the knowledge of responding to abuse and neglect and SIRS.

Requirement 8(3)(e) The approved provider must demonstrate that it has effective comprehensive clinical oversight to ensure the effective implementation of clinical policies and procedures and that all staff are familiar with the policies relating to antimicrobial stewardship, minimising restraint and open disclosure and this is practiced at service level.

# Other relevant matters:

The provider responded to the Notice to Agree on 12 June 2023 that was issued by Compliance on 2 June 2023. The provider advised on the 3 July 2023, that this was to be used for the response to the Assessment Team’s 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. | 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. | Non-compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-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. | Non-compliant |

Findings

The Quality Standard has been assessed as Non-compliant as three of the six specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who generally reported that they are treated with dignity and respect. The Assessment Team observed interactions between staff and consumers or representatives to be respectful and caring.

The service is located in a rural area, with the cultural backgrounds of consumers largely being Anglo-Australian. The service is reflective of this culture with celebration and adherence to Australian customs and traditions. While information about consumers’ cultural backgrounds is limited, consumers provided feedback that they are satisfied with how the service is culturally safe for them. While there is limited information in care planning documentation about how consumers’ cultural needs or ensuring services are culturally safe, consumers provided feedback that many staff know them well and did not raise any concerns about cultural safety.

The Assessment Team found that the service relies heavily on verbal communications to provide each consumer with current, accurate and timely information. Consumers confirmed they are kept informed about what is happening around the service by staff which enables them to exercise choice. Consumers said lifestyle staff will let them know what events are being held. The Assessment Team observed lifestyle staff informing consumers about activities that were being held.

The Assessment Team observed that the menu is displayed in several place throughout the service and the print is small and it is not easy to read. However, catering staff advise consumers about what is on the menu each day and takes their meal selections.

The following requirements 1(3)(c), 1(3)(d) and 1(3)(f) have been found to be Non-compliant.

The Assessment Team found that the service supports consumers to make connections with others and maintain relationships of choice. Consumers generally reported satisfaction with the day-to-day choices they are able to make; for example, about meal choices. However, the service does not have robust systems to ensure that consumers’ choices and decisions about their care are captured and acted on. In addition, the service does not have processes to ensure information about how the consumer wants others to be involved in their care is captured and acted on.

The Assessment Team interviewed consumers and representatives and received feedback that staff do not ask about consumer needs or choice. Care planning documents are not reflective of consumers’ individual preferences, for example in relation to when and how they wish care to be delivered. Consumers have not been involved in the development of their care plans to enable their choices to be captured as part of the care planning process.

The Assessment Team found that the service allows consumers to take risks to enable them to live the best life they can. However, they do not always undertake risk assessments to identify the risks presented for the consumer in relation to some activities they wish to take. Where risks assessments have been undertaken, they are not always reviewed as the consumer’s circumstances change.

The Assessment Team interviewed consumers who said staff respect their privacy and the Assessment Team observed staff ensuring consumers’ privacy by knocking prior to entering rooms and closing doors when attending to consumers in their room. However, the service does not have adequate systems to keep consumers’ personal information confidential.

The Assessment Team observed the nurses’ station to display a range of personal consumer information on whiteboards with a range personal information about consumers openly displayed. The nurses’ station was observed with the door wide open and no staff present on multiple occasions throughout the site audit. Large document bins containing consumers’ personal information awaiting destruction are not kept secure or locked.

The Assessment Team discussed the lack of security for the personal information with management. They agreed the security for the documents was insufficient and said they would follow up the matter.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions for toolbox education for staff on consumer privacy, offering choices and decision making for consumers. The service has also committed to updating care plans with preferences and to conduct review of consumers to ascertain any risk and ensure that risk assessments contain strategies to mitigate risks and provide a copy to consumer /representatives. The confidential documents bin will be replaced with a secure locked bin.

I acknowledge the actions that the provider will be implementing, however understand that this will take some time to reflect compliance with some action not due to be completed until the end of August 2023. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find the approved provider is not compliant with requirements 1(3)(c), 1(3)(d) and 1(3)(f).

# 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. | Non-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. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

The Quality Standard has been assessed as Non-compliant as five of the five specific requirements have been found to be Non-compliant.

The Assessment Team found that the service does not demonstrate assessment and planning, including consideration of consumers’ risks, informs the delivery of safe and effective care and services. The organisation has guides for initial assessments when consumers enter the service and policies and procedures to guide staff in assessment and care planning processes.

The Assessment Team identified consumers’ clinical assessments are not attended in alignment with the organisation’s policies and procedures. Consumers’ personal and clinical risks are not identified and managed in a timely manner to ensure safe and effective care and services are provided. Information in consumers’ clinical assessments is not always accurate and assessments omit key information required to plan the management of risks to their health and well-being. Assessments are not consistently carried out by suitably qualified staff.

The Assessment Team identified that there were gaps in assessment and care planning documentation and it was not reflective of care provided in relation to bowel management, pain and behaviours, wound care and falls management.

The service does not demonstrate consumers’ needs, goals and preferences are identified and addressed appropriately through the assessment and planning processes, including advanced care planning and end of life planning. Information in assessments and care plans is not consistently correct and does not direct staff in appropriate strategies to manage consumers’ needs, goals and preferences. Information in behaviour support plans was noted to be inaccurate and not accurately reflecting consumer’s needs, goals or preferences.

The Assessment Team identified that the service does not demonstrate all assessment and planning is based on ongoing partnership with consumers or their chosen representatives and includes other organisations or providers of other care and services. While most representatives said the staff contact them if their consumer experiences any changes or incidents, there is no evidence of ongoing partnerships with consumers or representatives on their behalf. The organisation has policies and procedures to guide staff to enable compliance with this requirement, however the service has not yet implemented a sustainable process for demonstrating assessment and planning is based on partnership.

Management advised that staff contact representatives following changes to consumers’ condition and following incidents, however they have not yet started to have scheduled care conferences to enable meaningful partnership with consumers or their representatives. They said they have commenced contacting representatives to invite them to case conferences. The Assessment Team observed this documented in two consumers’ progress notes. However, there is no schedule planned to monitor this program and no evidence of any case conferences being held. Management were not clear about how often case conferences would take place.

The Assessment Team found that the service does not demonstrate 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.

The Assessment Team interviewed consumers and representatives who were asked about how the service communicates outcomes of the assessment and planning. One representative said they had been shown a care plan when their consumer first came to the service, however all other consumers and representatives said they had not been aware of a care plan and were not aware they could access it.

The service does not demonstrate 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. While the organisation has policies and procedures relating to the review of care and services, clinical staff were not clear on what the expectation of the organisation was. They said they reviewed assessments (which populate into care plans) when changes occur, however were not sure how often regular care plan review takes place.

The Assessment Team identified incident management is not consistently effective in investigating and analysing causes, following up with appropriate monitoring and including new interventions to prevent re-occurrences. Not all incidents are documented to ensure appropriate review of care and services. This was identified where details of incidents were not being effectively investigated following falls and episodes of changed behaviours, pain and bowel care.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions including the provision of education to all staff on documentation, dignity of risk, and assessing risk in everyday care and education to managers at site on investigating and analysing incidents. The service has committed to developing a care conference calendar to ensure assessment and care plans are completed and reviewed in consultation with consumer/representative in timely manner and to identify their need’s goal and preference related to advance care planning and end of life planning.

I acknowledge the actions that the provider will be implementing, however understand that this will take some time to reflect compliance as the action’s completion date is 31 August 2023. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find that the approved provider is Non-compliant with these requirements.

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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. | Non-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. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-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. | Non-compliant |

Findings

The Quality Standard has been assessed as Non-compliant as seven of the seven specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who were generally satisfied with the personal and clinical care provided. However, the Assessment Team identified areas for improvement to ensure consumers receive safe and effective personal and clinical care that is best practice, tailored to their needs and optimises their health and well-being.

The Assessment Team identified best practice is not consistently utilised in planning and delivering personal and clinical care. The clinical nurse manager said the service uses the organisation’s policies and procedures which reflect best practice although they acknowledge the introduction of the new systems has not been smooth. Additionally, they acknowledged staff are not all following the new policies and procedures as they have not had training. They said the service utilises the nearby ambulatory care service for complex health issues such as wound advice and catheter care.

The service does not demonstrate best practice is utilised to manage consumers’ personal and clinical needs, goals and preferences. Pain is not assessed accurately, management strategies are not clearly documented or consistently used, and pain management strategies are not evaluated to ensure they are tailored to consumers’ individual needs and optimises their health and well-being. Bowel management, nutrition and hydration, wound care, pressure injury care, diabetic management, nutrition and hydration, behaviour management and sleep management are not consistently in line with best practice or tailored to consumers’ needs to optimise their health and well-being.

Consumers and representatives on their behalf are mostly satisfied with the care and services provided. One representative said the staff frequently make contact to ask advice in managing the consumer’s low blood glucose levels.

However, the Assessment Team found the service does not demonstrate effective management of high impact or high prevalence risk associated with the care of each consumer.

The Assessment Team was advised due to senior staff working across two services that staff contact them if there are any consumers involved in incidents. However, advised they do not review monitoring charts as part of their clinical oversight. The Assessment Team identified not all incidents are documented on incident reports and would therefore not be included in management reviews. Monitoring charts are not consistently capturing consumers’ high impact or high prevalence risks such as their changed behaviours or pain. Management was unable to provide documentation to confirm that care staff administering medications have been assessed as competent.

The Assessment Team identified that the service does not demonstrate informed consent is gained, or that chemical restraint is used as last resort and with a view to reducing the dose and ceasing.

The service does not demonstrate accurate falls risk assessments are undertaken. Strategies for post falls management are not carried out in line with the organisation’s policies and procedures. Appropriately skilled staff are not undertaking assessments such as neurological observations following falls with suspected head injury and pain assessment prior to and after administering schedule 8 PRN pain medication. Not all incidents of falls are documented on incident reports.

The service does not demonstrate the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. For one consumer sampled there was no evidence of consultation with the representative regarding end-of-life need, goals and preferences. Pressure injury care was not effective or monitored and the consumer had not been referred to a wound specialist. Pain was not accurately monitored or addressed and palliative crisis medication had not been considered.

The Assessment Team identified that the service did not recognise or respond to consumers’ changes or deterioration in consumers’ mental health, cognitive or physical function, capacity or condition. Suitably qualified staff are not following up identified changes adequately with potential and actual impacts on consumers' care. Staff are not following incident management in line with the organisational policies and procedures.

The Assessment Team found that the service does not demonstrate information about the consumer’s condition, needs, and preferences is documented and communicated within the organisation, and with others where responsibility is shared. Management advised that the organisation had implemented a new electronic clinical documentation in November/December 2022. A program of transferring all consumers' information including assessments and care plans from the paper-based system has not ensured consumers’ information is available or accurate. Management explained they have had to rush through consumers’ clinical assessments, and they acknowledge there are gaps in documentation. Staff said they are informed of each consumer’s condition, needs and preferences through handovers or other staff telling them and said they do not have time to review consumers’ clinical files.

The Assessment Team found that the service does not demonstrate consumers are referred to appropriate individuals, other organisations and providers of other care and services appropriately and in a timely manner. The Assessment Team found that for some consumers they had not had appropriate or timely referrals to speech pathologist, despite swallowing difficulties or behaviour specialist when consumers had a change in behaviours.

The Assessment Team identified that the service does not demonstrate readiness in the event of an infectious outbreak. Only one third of staff had received outbreak management training, the service was unable to provide evidence of staff training in PPE or handwashing. There was inaccurate recording of staff vaccinations. Staff were observed wearing their masks incorrectly, below their noses. The wound dressing trolley contained opened multi use dressing material which was not named or dated. The medication trolley contained opened eye drops which did not have an opened date.

The Assessment Team asked staff about antimicrobial stewardship and they responded they had not received training in antimicrobial stewardship at the service. Management did not find evidence training had been offered to staff. While the organisation has policies relating to antimicrobial stewardship, the Assessment Team found no best practice information relating to antimicrobial stewardship displayed for staff. The service does not demonstrate appropriate pathology testing is done to confirm consumers’ suspected infections, and to ensure appropriate antibiotic usage.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions for education on new clinical escalation pathway developed by organisation with guidelines on AIN scope of practice and recognising and assessing pain for all staff and escalation to clinical staff in a timely manner. Additional education is planned for assessing risk on everyday care and reporting risks to RN/CNM in timely manner, falls management and frequency of neurological observations. Toolbox talks will be provided on evaluating pain management and medication competency for staff. A memo was to be sent to staff to contact registered nurse on call or facility manager for clinical matters, administration of medication and there is a plan to recruit a fulltime Clinical Nurse Manger.

I acknowledge the actions that the provider will be implemented, however it will take some time to reflect compliance with some actions to be completed late August – late September 2023. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find that the approved provider is Non-compliant with these requirements.

# 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. | Non-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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard has been assessed as Non-compliant as two of the seven specific requirements have been found to be Non-compliant.

The Assessment Team found that the service generally ensures that each consumer gets safe and effective services and supports for daily living. Most consumers and representatives provided positive feedback about their satisfaction with living at the service and said they felt at home in the service. This included their satisfaction about how they are treated by staff, spiritual and emotional support and the ability to live their life in a way that enables them to pursue their interests and optimise their quality of life.

The Assessment Team found that the service demonstrates that services and supports for daily living generally promote each consumer’s emotional, spiritual and psychological well-being.

The Assessment Team interviewed consumers and representatives, who spoke fondly of the staff, and some stated they are always there when you need them. Most consumers at the service either identify as not having spiritual needs or as belonging to one of the mainstream Christian faiths. Services are held on a rotating basis each week by Catholic, Anglican and Baptist churches. Most consumers provided positive feedback about services and support they receive for daily living. The service supports consumers to be part of their local community and to have social and personal relationships, and to do things of interest to them. Most consumers either spoke positively about the lifestyle program or said that while they are not interested in the activities on offer at the service, they are able to independently pursue their interests. Some consumers spoke positively about the new lifestyle coordinator, who they said ensures they are given daily word puzzles and quizzes to ensure they have something to do.

The service assists consumers access their community through a volunteer driver, or if family or the volunteer are not available, the service arranges staff to accompany consumers. The lifestyle calendar is noted to have similar activities, such as bingo being offered on most days. The calendar is largely female oriented with limited male interests reflected in the calendar. The lifestyle coordinator, who commenced in the service 3 months ago, does not hold any qualifications in relation to the provision of lifestyle supports. They said they had not had previous experience in the role and have not received any training since commencing the role. They were unable to explain how they evaluate the effectiveness of the lifestyle program.

While some deficiencies were identified in relation to the lifestyle program, overall, consumers expressed satisfaction with program offered to them.

The Assessment Team found that the service undertakes timely and appropriate referrals to individuals, other organisations and providers of care and services. Three church groups visit the service on a rotational weekly basis. Consumers are supported by staff to attend local hairdressing services if needed. Some consumers have been referred to psychological and counselling services.

The following requirements 4(3)(d) and 4(3)(f) have been found to be Non-compliant.

The Assessment Team found that the service does not have effective processes to ensure information about the consumer’s condition, needs and preferences is communicated within the organisation or with others where responsibility for care is shared. Staff were not familiar with consumers’ spiritual needs. Care planning information about consumers’ spiritual, emotional and lifestyle needs is limited, contradictory and does not provide specific information about how the consumer’s needs and preferences would be met.

The Assessment Team found that most consumers are satisfied with the meals provided at the service. The menu offers a number of options at each meal. However, deficiencies in staff knowledge does not ensure that meals are always of a suitable quality to meet the needs of older consumers, particularly those with special dietary needs. While most consumers indicated satisfaction with the meal service, consumers advised that the chef does not understand the needs of aged care consumers. One consumer also said the meals were not prepared in an Australian way, and the vegetables were all chopped small and mixed together. The Assessment Team observed that this was the case when they observed the meals prepared by the chef on the first day of the site audit, although consumers were not observed to raise any concerns about the meal.

Management said the organisation had recognised they needed qualified chefs rather than just cooks in their services and had therefore recently employed a chef for this service who had trained and just come from overseas. They were unable to say whether the new chef had training in relation to meal preparation for older people but believed they had worked in aged care settings overseas. However, the new chef told the Assessment Team they did not have any previous aged care experience.

The chef said they have not been provided with any recipes for the menu and will prepare the meals to suit the description on the menu based on their knowledge of food preparation. When asked about training they had received for their role, the chef said they have not had any training because their access to the online learning modules the organisation uses is not working. The quality manager said the organisation’s executive chef came to NSW and spent a week orienting the new chef.

The Assessment Team observed that on day 1 of the site audit one consumer was served a pureed meal which appeared grey and unappetising with all the meat and vegetable pureed together. The Assessment Team observed that the consumer did not eat the meal. The chef said this was the way they believed pureed meals should be prepared. The quality manager said they understood that the consumer had requested their meals to be prepared in this way, however a staff member who works both as care staff and in catering said they had never known the consumer to request meals to be served this way. A cook who was working on the second day of the site audit told the Assessment Team that the consumer sometimes did not like the protein portion of the meal so will end up just eating the potato and that this was not good for them, so they had been experimenting with ways to prepare the meals and had introduced the technique of pureeing all the food items together because the consumer might eat more of the meal then and this will ensure the consumer is getting some protein. After feedback was provided to management about the consumer’s meal, the meals were observed to be finely chopped meat with separate vegetables. The Assessment Team were advised by the kitchen staff that they did not have knowledge of IDDSI (International Dysphagia Diet Standardisation Initiative) guidelines.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions to organise care conferences with consumers and representatives to capture consumer’s needs and preferences, to complete Key to me assessment mapped to therapy, leisure and lifestyle care plan, and to evaluate consumers spiritual needs are met via care conference. The service has committed to review consumers assessment/care plan in consultation and update with the correct information. The plan includes to conduct a consumer leisure and lifestyle survey to identify consumer’ choices of activities and incorporate this in activities calendar and to enrol the lifestyle coordinator in and appropriately qualified course. Toolbox education is to be conducted with staff about offering choices and decision making to consumers. Education is to be provided to staff on food safety and IDDSI Guidelines and provide consumers with the opportunity to review the proposed menu and provide input on meals they would like to ensure their menu choices are met.

I acknowledge the actions included in the Plan for Continuous Improvement that are to be implemented, however it will take some time to reflect compliance with these and other actions which are to be completed by 31 August 2023. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find that the approved provider is Non-compliant with requirements 4(3)(d) and 4(3)(f).

# 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Non-compliant |

Findings

The Quality Standard has been assessed as Non-compliant as two of the three specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who were overall happy with the service environment and feel a sense of belonging. All consumers commented positively about their rooms, the overall service environment and their experience of living at the service.

The Assessment Team observed the environment is welcoming, easy to understand and optimises each consumer’s sense of belonging, independence, interaction and function. The service has a simple layout consisting of consumer rooms in two directions from the main foyer which assists consumers with wayfinding. Identification of the consumer’s room is aided by a photograph of the consumer at the door. While the service environment is generally welcoming, outdoor areas were observed to be poorly maintained and not welcoming. In addition, some aspects of the environment and equipment maintenance presented risks to consumers.

The following requirements 5(3)(b) and 5(3)(c) have been found to be Non-compliant.

The Assessment Team observed the service environment enables consumers to move freely, both indoors and outdoors. The interior of the service is clean, comfortable and generally well maintained. However, the outdoor areas are poorly maintained with risks to consumer’s wellbeing evident. The service does not have robust maintenance systems to ensure effective maintenance of the service environment and equipment. The maintenance schedules being used in the service related to another of the organisation’s services and had not been adapted to the circumstances of Lee Roshana. It included areas of the service, equipment and the location of items which did not match the Lee Roshana circumstances. For example, it referred to multiple floors of a building and to areas such as ‘Haven’; it included equipment such as a bed bath which the facility manager said the service does not have. It was not apparent that a review of the Lee Roshana environment had been undertaken to include maintenance aspects specific to Lee Roshana. Management was unaware that maintenance schedules did not relate to Lee Roshana.

Prior to 26 April 2023 the service did not have a maintenance log to record reactive repairs and maintenance. Staff said previously maintenance requests would be logged in the service’s communication diary. The Assessment Team reviewed the diary back to the beginning of February 2023; there were no maintenance items listed. The reactive maintenance log shows that items have not been promptly attended to with a number of identified maintenance requirements outstanding since April 2023, however the pest control was addressed on the first day of the site audit and the exit alarm was also escalated.

Management said maintenance of outdoor areas was to be undertaken by the maintenance officer. While it was apparent that while lawns had been kept mown, garden beds were overgrown, and it was apparent they had not been attended for a very long time. Old equipment was thrown in an area near the back shed, which did not present a pleasant outlook for consumers using the rear outdoor areas.

Each consumer’s room has a small outdoor patio area. The patios were dirty and poorly furnished with chairs stacked, mismatched and old and faded furniture. They did not present as a welcoming place for consumers to sit.

Fire extinguishers were tagged as being due for maintenance in April 2023. Management was not aware that maintenance had not occurred and said the maintenance officer normally arranges this.

Safety data sheets observed in various locations throughout the service were out of date (dated 2016). The quality manager said she had asked for staff to check that the safety data sheets were current some time ago.

The Assessment Team reviewed meeting minutes and noted for one consumer the pendant alert had not been working for a number of months. Staff meeting minutes record that issues regarding the consumer’s pendant alert were discussed in the staff meeting in March 2023. There is no record of issues with the pendant alert in the communication diary, which staff said was being used at that time to record maintenance issues. Management advised the first time she heard about the consumer’s pendant alert not working was when the Assessment Team provided feedback about it. The consumer reported that they sustained a fall in the sunroom area and had to wait an extended period for staff to attend because the consumer could not alert staff to their fall.

The Assessment Team asked management about systems for maintenance and settings for pressure relieving devices. They were unaware of the process and suggested speaking with staff. Staff members said they were aware pressure relieving mattresses required a particular setting that related to the consumer’s weight but were unaware of what the lines on the setting of the pressure relieving device related to. When asked about how they would know the setting was correct they said for one consumer they would ask the consumer because they would be able to tell the staff what it should be.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions such as engaging a third-party contractor to maintain outdoor areas, implement a new site-specific fire exit plan and engage a new service provider to rectify current issues about fire safety of facility. Review of all equipment to ensure test and tagging is up to date and develop a maintenance schedule with all assets included in maintenance program with dates and provider and completion.

I acknowledge the actions that the approved provider has planned to implement, however note that it will take some time for these and other actions to reflect compliance and completion. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find that the approved provider is Non-compliant with requirements 5(3)(b) and 5(3)(c).

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

Findings

The Quality Standard has been assessed as Non-compliant as two of the four specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who said that they feel comfortable giving feedback and would feel comfortable complaining. They said they know how to provide feedback and make complaints or suggestions. Many of the consumers who had complained, felt listened to and thought their concerns were welcomed. Information about how to provide feedback and make complaints is available in the service.

Staff interviewed were able to articulate how they manage and record verbal and written complaints per the organisational feedback and complaints policy. The registered nurse said they fill out the complaint form and put it in the complaint box when a consumer raises a concern. However, the Assessment Team found that not all complaints are recorded and acted upon. Review of documents and information displayed shows consumers are encouraged to give feedback and raise concerns. Staff spoke of the practical ways they support consumers to provide feedback and complaints.

Consumers and representatives shared that they were provided with information about advocacy and language services to raise or resolve complaints or that they knew how to obtain this information if needed. None had recently used an advocacy or language service. However, a representative said they had been a strong advocate for their relative, and the service management team was receptive to this.

The Assessment Team observed information on how to access advocacy services such as Seniors Rights Services, Older Persons Advocacy Network (OPAN), and the Commission.

The following requirements 6(3)(c) and 6(3)(d) are found to be Non-compliant.

The Assessment Team found that the service was unable to demonstrate appropriate action or investigation is undertaken in response to feedback and complaints or that open disclosure is always used when things go wrong.

The Assessment Team identified deficiencies in the complaints register where complaints and feedback identified by consumers and representatives have not been documented or, if recorded, are not effectively managed or followed. The Assessment Team interviewed consumers and representatives who said improvements made were ineffective when they complained. One representative said the consumer had commented several times about their missing clothes and other items from their room before any actions were taken. Another representative said most of the complaints had been addressed, but they had to raise them on several occasions before they were actioned. The representative could not recall any acknowledgement or apology being provided.

Management advised that they follow up on complaints when they identify them and provide toolbox talks to staff, and issues with meals to chef and cleanliness issues are passed to the cleaner.

Staff interviewed said they were aware of the internal complaints system and would escalate any complaints to the registered nurses or the enrolled nurse; however, they said they were unaware of the concept of open disclosure and said they had not had training about open disclosure. When raised with the management team, they said the service would look into it as part of the new education schedule that the service team is creating and would include it in their plan of continuous improvement.

The Assessment Team received feedback from consumers and representatives which indicated that the service does not review their feedback and complaints to improve the quality of care and services. Management described how the service's complaints process is used to inform its plan for continuous improvement. However, feedback and complaints documentation reviewed by the Assessment Team identified that appropriate action is not taken to resolve complaints and that systemic improvements are not being made to the service as a result.

The facility manager said the service conducts consumer surveys to identify areas of concern and improve the quality of care and services. However, the service only had one survey conducted in April 2023 after the new organisation took over in August 2022. There were no other ways that the service had captured consumers’ feedback to improve the quality of care and services. In addition, management could not provide any examples of any improvements arising from complaints in the continuous improvement plan.

While the service management stated at the entry meeting that there were no actual trends in complaints data, following a conversation with consumers and representatives, it was identified that some complaints and feedback was not effectively reviewed or documented to improve the quality of care and services. For example, a complaint made by a consumer about their call pendant being broken only led to a discussion in the staff meeting in March 2023; however, the complaint has not been documented or the pendant fixed to demonstrate the complaint has been reviewed and the quality of service is improved; there was no evidence that reasons for the delay in addressing the complaint was analysed or improvements made to ensure issues are promptly addressed.

The failure of the service to capture complaint information does not enable effective trending and analysis of complaints to lead to improvement in care and services.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions for education for staff on advocacy services via OPAN online, provision of open disclosure and customer service – complaint management education to all staff, educate staff on reporting feedback electronically via PolicyConnect website where complaints are automatically submitted to facility manager upon entering.

Whilst I acknowledge these and other actions that the approved provider will implement, I understand that it will take some time to reflect compliance with the actions which have a completion date 31 August 2023. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find that the approved provider is Non-compliant with this requirement.

# 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

The Quality Standard has been assessed as Non-compliant as three of the five specific requirements have been found to be Non-compliant.

The Assessment Team found that the workforce is planned to enable the delivery and management of safe and quality care and services. The service management team spoke of adjustments made to the master roster over time to meet the needs of consumers. Consumers’ and representatives’ feedback and review of call bell response times indicated staff are responsive to most consumers’ needs. Consumers stated they do not wait long when using the call bell and there is always staff around to assist them when they need it.

The Assessment Team interviewed consumers and representatives and received feedback that was mixed regarding the adequacy of staff at the service. Representatives commented that they felt the service needed more regular staff but did not identify any adverse impact on the care of the consumer with the current staffing levels. Some consumers provided feedback that they don’t have to wait for too long for staff to assist and they get the services they need when they need them, but the staff do not have time to sit and talk with consumers.

The Assessment Team reviewed a sample of call bell data over a 4-week period, with 19 calls over the 10-minute acceptable wait time. Management advised there is a review of call bells over 10 minutes.

However, two consumers/representatives provided examples where there has been a delay in responding to their call bells and staff attending to their needs. This has impacted their ability to get to the toilet in time. The concerns were raised with the service management team, who acknowledged the issues raised and said they would follow up with the staff involved to document a plan for continuous improvement to address the concern.

The service does not have effective processes to ensure that when registered nurses are not on duty in the service, there is effective guidance materials for staff, and monitoring of staff practices, to ensure clinical matters are appropriately escalated and managed.

The Assessment Team found that overall, it was demonstrated that workforce interactions with residents are kind, caring and respectful of each resident's identity, culture and diversity. The majority of resident and representative feedback was very positive regarding workforce interactions they have. The Assessment Team observations were consistent with that feedback. Staff were observed interacting with consumers in a kind and respectful manner.

The following requirements 7(3)(c), 7(3)(d) and 7(3)(e) have been found to be Non-compliant.

The Assessment Team found that the service does not demonstrate that the workforce has the necessary skills and knowledge to meet consumers' needs competently. Staff are working outside their scope of practice.

The Assessment Team interviewed management who said that clinical assessments should be undertaken by registered nurses, however enrolled nurses are undertaking assessments. Care staff are undertaking clinical monitoring outside of their scope of practice with neurological monitoring. In addition, they are making clinical decisions about consumers’ condition and needs, including administration of as needed psychotropic medications without out any escalation to registered staff. There was no information provided to demonstrate that staff have had education and/or competency assessments in relation to neurological monitoring and other clinical tasks they are undertaking.

Management told the Assessment Team they thought there were 2 care staff who did not hold a certificate III or other relevant qualifications in aged care. However, when asked to provided details of staff who did not hold qualifications, it was established that a total of 8 care staff do not hold any aged care qualifications. Management advised a few are currently studying for qualifications. Management were unable to provide any documentation to demonstrate that these staff have had specific training (beyond normal buddy shifts) to ensure they have the necessary skills and competencies to undertake their roles. The facility manager could not provide medication competency for the care staff currently administering the medication to the consumers.

The Assessment Team found the service has systems in place for recruitment, training, equipment and support to deliver care to consumers. However, these systems are ineffective in delivering the standard of care required to meet consumers' needs. Staff have been trained on some topics at the start of the year in 2023. However, feedback from consumers and review of the care and services for the consumers sampled shows human resource processes have not been effective in ensuring staff competently undertake their roles.

On interview it was identified that lifestyle staff do not hold relevant qualifications. The new chef appointed several weeks ago said they had not completed any of the mandatory education because they have not had access to the online system. They have hospitality qualifications gained overseas but said they have not completed any food safety or other education in Australia. The chef and catering staff said they have not had any education about IDDSI (International Dysphagia Diet Standardisation Initiative).

The Assessment Team were advised that many new procedures have been introduced since the service’s ownership changed. They said staff have not been trained to follow the new processes, for example, post falls management assessment training and neurological observations training. They said while new assessments forms have been created to assist staff most of the staff do not use the forms as they are not being trained effectively.

Staff interviewed said they receive toolbox talk as part of education but could not detail any recent training apart from one they attended for continence management. Management advised that most of the current staff have not yet had adequate training. They said the service has identified this as a gap and has a plan for continuous improvement that is due to be completed by December 2023 to mitigate those concerns.

The Assessment Team found that the service was not able to demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The service has a performance appraisal system. The service's plan for continuous improvement (PCI) includes an action to review the performance appraisal tool. The service could not provide any performance appraisal record for any staff.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions to develop a clinical care escalation procedure when there is no registered nurse on site. Develop a training plan for the site that includes all the outstanding and required education and training and implementation of training to provide staff with the minimum qualifications required. The service will schedule and complete staff appraisals for staff, with toolbox education provided to staff for performance appraisal procedures.

Whilst I acknowledge the actions that the approved provider will implement, I understand that it will take some time to reflect compliance with the action completion date of 1 December 2023. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find that the approved provider is Non-compliant with requirements 7(3)(c), 7(3)(d) and 7(3)(e).

# 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. | Non-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. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

The Quality Standard has been assessed as Non-compliant as five of the five specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives and whilst most considered the service to be well run, they did not know how they could take part in deciding how things are run or how care is delivered at the service. The organisation is unable to demonstrate that it actively engages and supports consumers in the development, delivery and evaluation of care and services, and management were unable to provide examples of this. Information gathered through the assessment of other Standards showed that some of the feedback given by consumers (or their representatives) has not led to improvement in the care and services.

When asked how consumers are engaged in the development, delivery and evaluation of care and services, management could only provide examples of feedback mechanisms, consumer meetings and surveys but could not give any other examples of consumer engagement in the development, delivery and evaluation of care and services. The manager acknowledged that the organisation does not yet have mechanisms for actively partnering with consumers in the design, delivery and evaluation of care and services but said it is looking into engaging the consumers and representatives of the organisation’s various services through videoconference meetings, but this has not yet been formally added to the organisation’s plan for continuous improvement.

The Assessment Team found that the organisation’s governing body does not promote a culture that ensures safe and quality care and services and does not demonstrate it is accountable for their delivery. The Assessment Team asked management if a risk assessment or other process had been undertaken by the organisation following the purchase of the service to establish whether previously identified deficiencies had been addressed. Management said a consultant had managed the service until October 2022, when the organisation’s management team introduced the organisation’s systems to the service, however it was not provided to the service. The Assessment Team sought to understand whether the governing body had obtained that information or undertaken a risk assessment or similar themselves; management said any such information would be with the chief executive officer/approved provider, and they would seek to obtain that information for the Assessment Team; no further information was provided.

The organisation does not have a robust governing body system to oversee aged care services. Management said the organisation does not have a board of directors or similar governing body structure, and all governing responsibilities sit with an individual who is the approved provider and also the chief executive officer of the organisation. They said the organisation contracts the services of a consultant with clinical and aged care expertise who sits in on the organisation’s ‘partnership in excellence care’ meetings.

The organisation has a range of individual policies regarding aspects of clinical care; however, the quality manager said the organisation does not have an overarching clinical governance framework document and is drafting the framework about a commitment to safety and quality care and services.

The organisation demonstrates it has effective organisation-wide governance systems in relation to financial governance. However, organisational systems in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints have not been effective and/or have not been effectively monitored. The organisation did not demonstrate that it has local governance systems that feed into and are supported by the overall organisational governance framework and accountability structure.

The organisation has not ensured that their information systems are effective in gathering sufficient information to ensure the management and oversight of care and services provided. The organisation is not ensuring that the service is undertaking appropriate assessments to inform the delivery of care and documentation of aspects of care. There are inconsistencies in reports that are generated for review and actual occurrences.

The service demonstrated a plan for a continuous improvement system, including audits, feedback and observations which feeds into a continuous improvement plan is in place. However, the plan for continuous improvement does not identify the source from which continuous improvement initiatives are drawn, for example, consumer/representative feedback, feedback and complaints mechanisms, and internal audits. In addition, while some deficiencies have been identified as areas for improvement, there is limited information about monitoring to ensure the effectiveness of measures implemented to address deficiencies or evidence of monitoring to ensure effective improvement activities.

While the organisation has systems in place to provide workforce governance these systems are not effectively ensuring the workforce has the knowledge and skills to ensure that quality and consistency of care and services is being provided to consumers in accordance with the Quality Standards.

The organisation did not demonstrate that appropriate measures have been put in place to ensure effective systems are implemented in a timely manner to ensure the organisation prepares for and implements regulatory changes. The organisation has not ensured, an effective incident management system is in place as required under SIRS regulatory requirements.

The Assessment Team found while there are systems in place for feedback and complaints management, the organisation has not ensured that those systems are effectively implemented at the service. Management were unable to provide any examples of improvements made by the governing body in the organisation as a result of consumer feedback.

The Assessment Team found that the organisation does not have effective process for risk management which are effectively monitored; including in relation to managing high-impact or high prevalence risks, support for consumers to live the best life they can and managing and preventing incidents. In addition, staff have not received education about responding to abuse and neglect and were unaware of SIRS.

The organisation does not have an overall clinical governance framework and management said they are currently drafting the clinical governance framework that will include policies concerning antimicrobial stewardship, minimising restraint and open disclosure. The organisation has not ensured comprehensive clinical oversight to ensure the effective implementation of clinical policies and procedures. While the governance framework is being drafted. It includes policies relating to antimicrobial stewardship, minimising restraint and open disclosure that outlines the responsibilities, structures, and expectations. However, it is not always understood and practised at the service level.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The Plan included actions for improvement with care conferences to be offered to consumers and representatives. The organisation will provide further education on the organisation’s policies and procedures and will educate managers on the auditing system, process and purpose. The organisation will provide further education to staff in line with the training plan including SIRS and will ensure staff are provided with education on accessing the organisation’s frameworks and monitor the staff compliance with these. Education will be provided to clinical staff on incident management, restrictive practice monitoring including chemical restraint and all staff on assessing risk for everyday care and open disclosure. The organisation will employ appropriately qualified staff to complete assessment and care planning and for clinical oversight. A clinical care escalation procedure when the registered nurse is not onsite has been developed and is in place.

I acknowledge the actions that the approved provider is initiating, however understand that it will take some time to reflect compliance. It is also noted that the Plan for Continuous Improvement does not include outcomes to measure how the service will evaluate that the actions introduced reflect compliance and are sustainable.

I find the approved provider is Non-compliant with these requirements.

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