Performance

Report

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| Name: | Lee Roshana Care |
| Commission ID: | 0327 |
| Address: | 1 Queen Street, BLAYNEY, New South Wales, 2799 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 February 2024 to 8 February 2024 |
| Performance report date: | 11 March 2024 |
| Service included in this assessment: | Provider: 7020 Burswood Care Pty Ltd  Service: 343 Lee Roshana Care |

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 G-M. Cain, 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 28 February 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **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 applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The performance report dated 12 July 2023 found the service non-compliant in 3 Requirements under Standard 1.

* Requirement 1(3)(c)
* Requirement 1(3)(d)
* Requirement 1(3)(f)

Deficiencies related to consumers’ choices and decisions about their care not being consistently captured and acted on, for example information about how the consumer wants others to be involved in their care; inconsistent assessments of risk/s to enable consumers to live their best life; and consumers’ personal information not consistently managed confidentially.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

Consumers and representative expressed satisfaction with the improvements made at the service, and advised they are involved in making choices about consumers’ care and services. Care documentation reflected consumers’ preferences and choices are documented and staff described how they provide individualised care and services to each consumer according to their wishes and choices. Observations showed staff consistently engaging with consumers and involving them in decisions and choices prior to provision of care and services.

Consumers are supported to take risk/s to enable them to live their best life, and consumers and representatives spoke of being provided information to support in this process. Care documentation reflected risk identification, assessments and review, including strategies on how to support consumers in undertaking their chosen activities. Staff demonstrated understanding of potential risks to individual consumers, how these are managed, and this was observed for a named consumer with staff ensuring the consumers’ safety in the event of a seizure episode.

Consumers are satisfied the service ensures their privacy is respected and confidentiality is maintained. Consumer information is maintained in the service’s secure electronic documentation system which requires unique details of an individual to enable access, and paper-based consumer information is stored in a secure locked cupboard which is accessible by management.

Improvement actions included (but were not limited to):

* The service engaged a nurse advisor to support in improvement activities, including the evaluation and audit of improvement actions.
* Implementation of ‘Partnerships in Care’ to ensure the consumer, and others the consumer wishes, are involved in care and services.
* A review of the service’s assessment and care planning procedure to ensure staff are guided in the identification of and managing risks in consumers’ care.
* Education for staff in a variety of areas including, person-centred care, assessment and care planning and respecting consumers’ privacy.

I have considered the Assessment Contact Report alongside the response submission, it is my decision that Requirement 1(3)(c), Requirement 1(3)(d) and Requirement 1(3)(f) are Compliant.

# Standard 2

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

Findings

The performance report dated 12 July 2023 found the service non-compliant in 5 Requirements under Standard 2:

* Requirement 2(3)(a)
* Requirement 2(3)(b)
* Requirement 2(3)(c)
* Requirement 2(3)(d)
* Requirement 2(3)(e)

Deficiencies relating to:

* Assessment and planning not identifying and the timely implementation of strategies to managed risk/s associated with consumers clinical and personal care. Assessments were not consistently carried out by suitably qualified staff.
* Consumers’ needs, goals and preferences were not consistently identified and addressed appropriately through the assessment and planning processes, including end of life wishes.
* The assessment and care planning process did not consistently involve consumers or their chosen representatives, or other organisations or providers of care and services.
* The outcomes of assessment and planning were not effectively communicated to the consumer, or documented in a care and services plan that is readily available.
* The regular review of consumers’ assessment and care plans including when an incident occurs were not completed.

*In relation to Requirement 2(3)(a)*

The Assessment Contact report contained information evidencing some improvements in the services assessment and planning processes, consumers and representatives expressed satisfaction and spoke of improvements made by the service. Staff demonstrated understanding of the service’s assessment and care planning processes, the service utilises validated risk assessment tools and this was confirmed on review of individual consumers’ care documentation. Improvements included the review of services procedures, implementation of a risk register and risk/incident checklists, clinical audits, increased oversight by clinical management and training for the workforce. However, the Assessment Contact report identified deficiencies in the assessment and planning for consumers at risk of experiencing seizures and consumers subject to restrictive practices. Specifically:

* For one named consumer, who experiences seizures which may result in a loss of consciousness and subsequent fall, care documentation did not evidence assessment of this risk and the implementation of strategies to minimise risks.
* For a second named consumer, identified by the service as subject to chemical restrictive practice, a current behaviour support plan was evidenced, however, did not include information relating to the assessments of risk/s or strategies to be implemented to minimise risk/s including using restrictive practice as a last resort.

The Approved Providers response submission included a plan for continuous improvement and care documentation for the named consumers:

* For the first name consumer, a copy of a seizure management plan (dated 7 February 2024) identified the risk of loss of consciousness and falls related to a seizure; and strategies staff are to take in the event of a seizure.
* For the second name consumer, a copy of the behaviour support plan was provided which evidenced assessed risks, and guidance for staff (including non-pharmacological) to be implemented when the consumer presents with changed behaviour.

In coming to my decision, I have considered the Assessment Contact report alongside the response submission, and I am satisfied the service’s assessment and care planning processes include the consideration of risk/s. For the 2 named consumers, the service has taken immediate action in respond to the deficiencies and has implemented improvement strategies to ensure sustainability of these actions. It is my decision Requirement 2 (3)(a) is Compliant.

*In relation to Requirement 2(3)(e)*

The Assessment Contact report contained information evidencing some improvements in the services assessment and planning processes, however, ongoing deficiencies were identified in the review of assessment and planning for consumers following a change in mobility, falls risk, nutrition and hydration, restrictive practice, and other complex care issues such as management of medication self-administration, and diabetes.

* For 9 named consumers, assessment and care planning documentation was not updated with recommendations after review by the dietitian.
* For one named consumer, the diabetic care plan was not contemporaneous including the update of directives for blood glucose monitoring after the consumer was reviewed by the medical practitioner.
* Five consumers subject to restrictive practice were not consistently reviewed in accordance with the organisation’s ‘restrictive practices prevention and management policy and procedure’. The policy and procedure directed the restrictive practices comprehensive assessment must be completed as soon as practicable after a relevant change in consumers’ circumstances and, in any event, annually or more frequently in accordance with the consumer’s individual needs and preferences, and in any changes in their condition.’
* For 2 named consumers who were identified as at high risk for falls, the falls risk assessments completed by the registered nurse assessed the consumer as a medium risk, however the physiotherapist assessment identified the consumers at a high risk. As a result, information within the consumer’s transfer and mobility plans were conflicting.
* For 5 named consumers identified by the service as being supported to self-administer some medications, medication self-assessments were completed, however this information was not reflected in the consumers’ self-medication care plan.

The Assessment Contact report evidenced the service had taken immediate actions to these identified gaps at the time of the Assessment Contact.

The Approved Providers response submission included a plan for continuous improvement, care documentation for some of the named consumers and further clarifying commentary. The response submission identified:

* For the consumers subject to restrictive practices, previous assessments had been archived in the electronic care documentation system. The plan for continuous improvement (provided as part of the response submission) identified improvement actions including enhancement of the service’s care documentation system to automate processes once care assessment/care plans are archived.

In relation to other identified gaps, including the assessment, review and updating of care documentation for consumers following a change in nutrition and hydration, diabetic management, falls management and consumers who self-administer medication, the plan for continuous improvement evidenced immediate actions taken by the service. In addition, the plan for continuous improvement has comprehensively documented ongoing evaluation for ensure the effectiveness of these improvement actions. In coming to my decision, I acknowledge the immediate actions taken by the service, and ongoing actions as detailed in the service’s plan for continuous improvement. I am satisfied that the plan for continuous improvement effectively describes how the service will address the deficiencies identified and I am satisfied that Requirement 2(3)(e) will be compliant through the implementation of these proposed actions.

In relation to the remaining Requirements, the Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance.

Consumers and representatives confirmed that the assessment and planning process included considering consumers' needs, goals, and preferences and that staff had discussed end-of-life planning with them. Care documentation identifies consultation with consumers and representatives, including developing advanced care plans, if they choose to do this. Staff could describe how the assessment and care planning process identifies consumers' goals, needs and preferences to inform care delivery.

Consumers and representatives spoke of improved communication and ongoing partnership with the service in the assessment, planning, and review of consumers care and services. Staff described how they involved consumers, representatives, and others as appropriate in the assessment and review processes including 3 monthly care plan reviews and annual case conferences. Care planning documents evidenced consumers, representatives, and other providers of care and services were regularly engaged and involved in the assessment and planning process for consumers.

Consumers and representatives were aware of how to access a copy of their care plan. Staff described how they documented and communicated the outcomes of assessment and planning to consumers, representatives, and others in a timely and appropriate way. For example, staff explained communication is provided in accordance with the consumers and/or their representatives preferred method including through telephone, email or in person.

Improvement actions included (but were not limited to):

* Implementation of ‘Partnerships in Care’ to ensure the consumer, and others the consumer wishes, are involved in care and services.
* The implementation of resident of the day, 3 monthly care plan reviews and an annual case conference schedule.
* Provision of a care plan summary to consumers and representatives following the case conference or upon request.
* Education for staff in a variety of areas including the assessment and care planning process and investigating and analysing incidents.
* Ongoing clinical oversight by the organisation’s quality and risks team through the reviewing of consumers care documentation to identify and support in clinical reviews and incident investigations.

I have considered the Assessment Contact Report alongside the response submission, it is my decision that Requirement 2(3)(b), Requirement 2(3)(c) and Requirement 2(3)(d) are Compliant.

# Standard 3

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

Findings

The performance report dated 12 July 2023 found the service non-compliant in the 7 Requirements under Standard 3.

Deficiencies related to:

* Best practice not consistently utilised in planning and delivering consumers’ personal and clinical care, including the completion of informed consent for chemical restrictive practice and demonstration that restrictive practice was used as last resort.
* The effective management of high impact or high prevalence risk associated with the care of each consumer, including post falls.
* The needs, goals and preferences of consumers nearing the end of life were not consistently recognised and addressed, and consumers’ comfort maximised, and their dignity preserved.
* The service did not recognise or respond to changes or deterioration in consumers’ mental health, cognitive or physical function, capacity, or condition. Including, suitably qualified staff following up identified changes adequately, resulting in potential and actual impacts on consumers' care.
* Ineffective information sharing, about the consumer’s condition, needs, and preferences within the organisation, and with others where responsibility is shared.
* Referrals to appropriate individuals, other organisations and providers of other care and services were not actioned appropriately and in a timely manner.
* Infection prevention and control were not effectively managed, including preparedness in the event of an infectious outbreak. Staff were not trained in outbreak management and infection prevention and management practices.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

Consumers considered they received care that was safe and right for them, consistent with their needs and preferences, and supported their well-being. Consumers spoke of being happy with the care provided, including how the service is ensuring their needs, goals and preferences are meet such as the administrative of time-sensitive medications at the appropriate time. Care documentation evidenced that care is safe, effective, and individualised to each consumer. For consumers subject to restrictive practice, documentation reflects appropriate authorisations, behaviour support plans, monitoring and review. I have further considered the risk assessment and ongoing review of restrictive practices under my decision for Requirement 2(3)(a) and Requirement 2(3)(e). The service had policies, procedures, and other guidance to support staff in personal and clinical care delivery. Observations showed staff delivering care and services that promote safe and effective care, for example, regular repositioning of a consumer who had a current pressure injury including the utilisation of specialised pressure relieving equipment.

Consumers and representatives were satisfied that risks, including changed behaviours, pain, medication, diabetes, restrictive practices, and falls were effectively managed. Staff were aware of consumers' risks and strategies in place to minimise the risk. Care documentation identified strategies were in place to manage the consumers' identified risks, including directives from health professionals. Policies, procedures, and clinical protocols guided staff in the management of high-impact, high-prevalence risks.

Care documentation showed that consumers nearing end-of-life had their dignity preserved and care provided in accordance with their needs and preferences. Advanced care plans outline consumers' needs, goals, and preferences. Staff provided practical examples of maximising consumers' comfort, such as skin and mouth care and monitoring of pain.

Consumers and representatives expressed confidence in staffs’ knowledge and skills, including identifying changes in the consumers’ condition in a timely manner. Staff demonstrated knowledge and skills in managing various signs of deterioration such as physical and mental decline and care documentation evidenced timely identification and response to deterioration or changes in consumers' health and condition.

Consumers and representatives spoke of confidence that consumers’ needs and preferences are effectively communicated. Staff advised information was accessible to them to guide the delivery of consumer care and services, and described how information is shared within the organisation and with other providers of care and services such as through shift handover and printed handover sheets. The Assessment Contact report contained information in relation to 2 consumers, where inconsistent information was documented on the shift handover sheet. Immediate action was taken by the service in response to this, and the Assessment Contact report did not identify any impact to consumers because of this.

Consumers and representatives were satisfied with the access and availability of medical officers, allied health professionals, and other external specialist services when they needed. The service had implemented an electronic referral process, and this was described by management and staff. Care documentation confirmed the referral to and input of others in consumers' care and services.

The service had policies and procedures to guide staff in infection prevention and management, including the development of an outbreak management plan. Training recorded identified all but 1 staff member (who was on leave) had completed infection control training, personal protective equipment and hand hygiene competencies, and antimicrobial stewardship. Staff demonstrated knowledge of antimicrobial stewardship, and explained ways they promoted appropriate antibiotic prescribing. The service had an appointed Infection Prevention and Management Lead, and further staff are enrolled to complete this training to ensure the service is always supported. The service had infection prevention and control measures in place, such as an adequate supply of personal protective equipment, COVID-19 rapid antigen testing, temperature checks and health screening requirements as a condition of entry to the service for staff and visitors every 72 hours.

Improvement actions included (but were not limited to):

* A registered nurse is now rostered on-site and on-duty at the service 24 hours, across 7 days of the week to provide clinical oversight. A nurse practitioner provides additional clinical oversight and support to clinical team on-site and remotely.
* A review of policies, procedures, and guidance relevant to this Standard including falls management and diabetes management.
* The review of clinical indicators and clinical incidents to identify trends or emerging consumer risks. The service’s clinical management system dashboard creates alerts and live updates of consumers’ risks and current needs, and incidents are discussed during the service’s weekly clinical and risk meeting.
* Induction and ongoing training program for staff support utilisation of contemporary best practices in personal and clinical care. Ongoing education for staff in a variety of areas including advance care and end of life planning needs and identification and responding to consumer deterioration and changes in care.
* The development and implemented of a weekly handover sheet to ensure consumers’ current information and changes in care are handed over to relevant staff in a timely manner.

It is my decision that Standard 3 is Compliant, as the 7 Requirements under this Standard are Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The performance report dated 12 July 2023 found the service non-compliant in 2 Requirements under Standard 4:

* Requirement 4(3)(d)
* Requirement 4(3)(f)

Deficiencies related to the service not having 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; and staff knowledge regarding individual consumer needs, such as special dietary needs.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

Lifestyle care plans and ‘Key to me’ assessments are completed for each consumer, and detailed personalised information about their life history and present preferences and requirements. For one named consumer, the service is engaging with the Buddhist Centre to connect with the consumer through visitations at the service. Staff explained how they shared information about consumers to support the delivery of care and services with staff, and others as appropriate, such as documented shift handovers. Documentation demonstrated information about consumers was effectively shared, for example, the kitchen is notified and maintains a list of consumers’ dietary requirements displayed on a board in the kitchen to support the delivery of appropriate and correct meals.

Consumers advised the meals provided at the service were good, that they always had meal choices and have noticed improvements in the quality of the food, the menus, and food preparation. Management described how the menu was developed and considered the needs of consumers, including consumers’ requiring texture modified diets. The service holds food committee meetings, and review of service documentation demonstrated consumer input into the menus, food choices and preferences. Menus are reviewed and approved by a qualified dietitian prior to implementation of the seasonal menu.

Improvement actions included (but were not limited to):

* Completed ‘Key to me’ assessments for consumers to inform the therapy, leisure and lifestyle care plan.
* Consumers’ spiritual needs were discussed at care conferences to ensure strategies are implemented to meet these individualised needs.
* Completion of surveys to identify consumers’ activity choices and incorporate these into the activities calendar.
* Education for staff on food safety and the International Dysphagia Diet Standardisation Initiative guidelines.
* Consumers were engaged in the review of the proposed menu and provided feedback on meals to ensure their menu preferences are met.

It is my decision that Requirement 4(3)(d) and Requirement 4(3)(f) are Compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The performance report dated 12 July 2023 found the service non-compliant in 2 Requirements under Standard 5:

* Requirement 5(3)(b)
* Requirement 5(3)(c)

Deficiencies related to the service environment being poorly maintained resulting in potential risks to consumers safety; and ineffective maintenance systems to ensure planned and reactive maintenance is actioned for the service environment and equipment.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

The service had implemented systems and processes to ensure the provision of a safe, clean and well-maintained service environment including furniture and equipment:

* Maintenance schedules specific to the service environment, including a fire exit plan. Observations showed fire exit maps displayed around the service with easy-to-follow directions to the nearest exit. All illuminated fire exit signs were in good working condition and fire safety equipment was noted to be last checked November 2023.
* The implementation of an electronic service maintenance management system, which ensures the recording of all maintenance requests for timely actioning.
* Contracted services maintain outdoor areas and service various equipment and appliances in the service environment.
* Maintenance checklists were developed for preventive maintenance and detail specific assets and dates for completion.
* Observations showed the service took prompt actions after feedback discussions such as moving the staff smoking area to a more appropriate and safer area within the service and the maintenance supervisors on call arrangements.

It is my decision that Requirement 5(3)(b) and Requirement 5(3)(c) are Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The performance report dated 12 July 2023 found the service non-compliant in 2 Requirements under Standard 6:

* Requirement 6(3)(c)
* Requirement 6(3)(d)

Deficiencies related to the service being unable to demonstrate that concerns raised by consumers or representatives are effectively addressed, including the use of an open disclosure process when things go wrong; or that feedback and complaints are reviewed and used to improve the quality of care and services for consumers.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

Consumers and representatives spoke of being satisfied with the timely actions taken by the service in response to feedback or a complaint, and said management and staff offer an apology when things went wrong. Management and staff demonstrated knowledge of complaints management and the principles of open disclosure, and explained the processes used to address and resolve complaints or incidents. Staff have received training in open disclosure, and this was evidenced in training records. A review of the service’s incident records identifies that staff and management apply an open disclosure process following an adverse event, and details of the open disclosure process are documented.

Overall, consumers and representatives said the service listened to their feedback and complaints, took appropriate action to resolve concerns, and implemented changes to care and services. All consumers and representatives confirmed there had been improvements in consumer care and services, particularly in food. Management described the process of reviewing complaints, feedback, and incidents to inform improvements to care and services, as evidenced on the service’s plan for continuous improvement and other service documentation.

Improvement actions included (but were not limited to):

* A review of the feedback and complaints management processes, including the implementation of a regular review of consumer feedback at the weekly clinical risk and review meeting to ensure the review, analysis, trending, and actioning of complaints and incidents.
* Education for staff on open disclosure and the feedback management system, including feedback and complaints reporting and management processes.
* The implementation of a schedule of consumer surveys as an avenue for consumers to provide feedback and inform continuous improvement opportunities at the service.

It is my decision that Requirement 6(3)(c) and Requirement 6(3)(d) are 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. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The performance report dated 12 July 2023 found the service non-compliant in 3 Requirements under Standard 7:

* Requirement 7(3)(c)
* Requirement 7(3)(d)
* Requirement 7(3)(e)

Deficiencies related to the workforce not having the qualifications and knowledge to perform their roles, including non-clinical staff completing consumers assessments, staff not being provided appropriate education and training to effectively perform their roles including assessment of competency; and the assessment, monitoring and review of the performance of each member of the workforce was not undertaken.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

Consumers and representatives spoke of feeling confidence in the workforce and that staff are properly trained, knowledgeable, and qualified to meet consumer needs. The service had policies, procedures, staff training, and systems to ensure staff were qualified, and had up-to-date qualifications and knowledge to effectively perform their role. Management and staff described how the workforce is monitored and supported through recruitment processes, orientation and ongoing training, feedback, regular meetings, and competency and skill assessments. For example, the service completed annual medication competency assessment for all registered staff and care staff credentialled to administer medications. Staff demonstrated understanding of their scope of practice and provided examples where the skills of a registered nurse are required.

Consumers described the improvements they had observed in staff knowledge and skills. One consumer spoke of staff being paired with more experienced staff, and a second consumer described how staff are trained on strategies to minimise his falls and ensure his safety. The workforce was supported to deliver the outcomes required by these standards through education and training and formal recruitment processes. Interviews with staff and service documentation confirmed the workforce received training during their orientation and induction and regularly throughout the year which included training in a variety of clinical care topics, the Serious Incident Response Scheme, restrictive practices, behaviours management and infection control.

Consumers spoke of staff performing their job well and fulfilling their duties, one consumer spoke of staff ‘going above and beyond’. Staff advised that appraisal of their performance was reviewed 6 monthly during the probation period and then annually, and this was confirmed on review of service documentation. Management described a range of methods for evaluating staff performance, including formal performance reviews, staff and consumer feedback, informal feedback mechanisms, and observations. The service had a guideline for managing and implementing performance reviews are outlined in the organisation's ‘Human resources - performance management and misconduct policy’.

Improvement actions included (but were not limited to):

* The development and implementation of a staff training program that includes mandatory units for all staff and role-specific mandatory training. A staff training register and matrix was developed, which is maintained at the service with senior management oversight from a corporate level.
* A review and update to the service’s induction and orientation program to include the completion of mandatory education and training as part of the induction program and annually thereafter.
* A review of the staff performance appraisal tool and supervision procedures to include an ongoing review of staff competency, identification of training needs, and development of training plans.
* The implementation of staff appraisal and staff supervision schedules for all staff members.

It is my decision that Requirement 7(3)(c), Requirement 7(3)(d) and Requirement 7(3)(e) are Compliant.

# Standard 8

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

Findings

The performance report dated 12 July 2023 found the service non-compliant in 5 Requirements under Standard 8:

* Requirement 8(3)(a)
* Requirement 8(3)(b)
* Requirement 8(3)(c)
* Requirement 8(3)(d)
* Requirement 8(3)(e)

Deficiencies related to mechanisms to engage consumers in the development, delivery and evaluation of care and services; the governing body did not demonstrate it had promoted a culture that ensures safe and quality care and services or ensured mechanisms are in place to ensure it is accountable for their delivery; the organisation did not demonstrate effective organisation wide governance systems are in place including risk management and clinical governance.

The Assessment Contact report following a visit from 6 February 2024 to 8 February 2024, identified the service demonstrated actions to improve its performance under these Requirements as evidenced in the service’s plan for continuous improvement and other service documentation.

Consumers and representatives said they were engaged in developing and delivering their services through care planning meetings, day-to-day feedback, meetings, and surveys. Consumers spoke of being consulted about mealtimes, the food service and individual care and service preferences. Management described how consumers are encouraged to provide feedback in various informal and formal ways, and feedback reviewed and analysed to identify trends and opportunities for improvement. The service’s plan for continuous improvement and other service documentation evidenced feedback received from consumers about their care and services.

Consumers spoke of feeling included and safe at the service and described how management asks for their opinions and needs which shapes how the organisation is run. Management described how they are supported by the newly established governing body in the promoting of safe, inclusive, quality care and services culture. The organisation had a tiered approach to ensuring accountability and responsibility, including service operations and the clinical governance committee with reporting processes to the governing body.

The service demonstrated organisation-wide governance systems to support effective information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints management. For example:

* Opportunities for continuous improvement at the service are drawn from various sources, including consumer and representative feedback and complaints mechanisms, consumer survey results, and clinical and incident data analysis.
* The organisation had processes for workforce management including staff performance management, recruitment, and staff restructuring. The organisation had undertaken a review and restructure of the service’s staffing profile based on occupancy rates and consumer acuity resulting in the employment of additional registered nurses and a clinical nurse manager.
* The organisation’s clinical governance committee monitors and collates legislative and regulatory changes from peak aged care bodies and the Commission. This information is disseminated to the service and communicated to consumers, representatives, staff, and other stakeholders.

The organisation implemented effective organisation-wide governance and risk management systems and practices to prevent and manage incidents and to identify and respond to abuse and neglect of consumers. Management described the changes to the service’s reporting mechanisms following the establishment of the Board and implementation of the organisation’s clinical governance framework. Risks are reported, escalated, reviewed, and analysed at a service and organisational level and communicated through organisational meetings including reporting to the Board. A review of the service's Serious Incident Response Scheme notifications identified 2 incidents which had both been reported in line with legislative requirements.

The service had implemented a clinical governance framework providing an overarching monitoring system for clinical care. The framework addressed the key clinical governance areas of antimicrobial stewardship, minimising the use of restrictive practices, and open disclosure. The service is supported by a suite of updated clinical policies and procedures to guide staff practice, and staff demonstrated a shared understanding of these policies and could describe how they apply these as relevant to their roles. A review of the clinical governance committee meeting minutes identified oversight of the use of antimicrobials, analysis of usage to identify trends and subsequent actions. Antimicrobial stewardship was observed to be a standing agenda item in the medical advisory committee meeting where the appropriate prescribing of antibiotics was discussed.

Improvement actions included (but were not limited to):

* The development and implementation of improvements relating to engaging consumers in the development, delivery and evaluation of care and services. Including Implementation of ‘Partnerships in Care’; a resident of the day, 3 monthly care plan reviews and an annual case conference schedule; and the provision of a care plan summary to consumers and representatives following the case conference.
* The review and updating of the organisations audit procedure to align its audit criteria with the Quality Standards. A designated member of the clinical governance committee conducts regular clinical audits in addition to the audit schedule.
* Implementation of a risk management and incident management framework that describes consumer risks in care and system for identifying, rating, analysing, reporting, and responding to risks and incidents. Staff had received training in key elements, including the Serious Incident Response Scheme.
* Management and clinical staff received education and training on incident and risk management.

It is my decision that Standard 8 is Compliant, as the 5 Requirements under this Standard are 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)