Performance

Report

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| Name of service: | Lilliane Brady Village Hostel |
| Service address: | 2 Nullamutt Street COBAR NSW 2835 |
| Commission ID: | 0366 |
| Approved provider: | Cobar Shire Council |
| Activity type: | Site Audit |
| Activity date: | 20 June 2023 to 22 June 2023 |
| Performance report date: | 21 August 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 Lilliane Brady Village Hostel (**the service**) has been prepared by J. Howard, 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 conducted from 20 June 2023 to 22 June 2023. The site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The provider’s response to the Assessment Team’s report, received 2 August 2023.
* Other information and intelligence held by the Commission in relation to this service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | 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 | **Compliant** |
| **Standard 5** Organisation’s service environment | **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 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.
* ***Requirement 3(3)(a)*** **–** each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

i) is best practice; and

ii) tailored to their needs; and

iii) optimises their health and well-being.

* ***Requirement 6(3)(d)*** *–* feedback and complaints are reviewed and used to improve the quality of care and services*.*
* ***Requirement 7(3)(d)*** *–* the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards*.*
* ***Requirement 7(3)(e)*** – regular assessment, monitoring and review of the performance of each member of the workforce.
* ***Requirement 8(3)(a)*** *–* consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* ***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.
* ***Requirement 8(3)(c)*** – effective organisation wide governance systems relating to the following:

i) information management

ii) continuous improvement

iii) financial governance

iv) workforce governance, including the assignment of clear responsibilities and accountabilities

v) regulatory compliance

vi) feedback and complaints.

* ***Requirement 8(3)(d)*** – effective risk management systems and practices, including but not limited to the following:

i) managing high-impact or high-prevalence risks associated with the care of consumers

ii) identifying and responding to abuse and neglect of consumers

iii) supporting consumers to live the best life they can

iv) managing and preventing incidents, including the use of an incident management system.

* ***Requirement 8(3)(e)*** – where clinical care is provided – a clinical governance framework, including but not limited to the following:

i) antimicrobial stewardship

ii) minimising the use of restraint

iii) open disclosure.

# Standard 1

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

Findings

The Quality Standard is assessed as Compliant, as six of the six specific requirements were assessed as Compliant.

Consumers were treated with dignity, respect and staff valued them as individuals. Staff were respectful to consumers and understood their individual backgrounds and preferences, which were recorded in care plans. Consumers confirmed they received culturally safe care and services and staff provided care consistent with their traditions and preferences. Consumers were supported to communicate decisions about their care and maintain relationships of choice. Consumers’ care plans included information about how care should be delivered, who was involved in their care and how the service supported them to maintain personal relationships.

Consumers were supported to take risks, exercise choice and maintain independence, which enabled them to live their best lives. For consumers wishing to take risks, their care plans included those risks and showed they were reviewed for appropriateness. Consumers confirmed they were provided with information that was clear, easy to understand and enabled them to make informed decisions. For example, consumers received information via activity schedules, daily menus, by e-mail, verbally from staff and on noticeboards throughout the service. Consumers’ personal information was kept confidential in a password-protected electronic care management system and staff respected consumers’ privacy by ensuring doors were closed when providing care.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| 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. | 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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 2(3)(a).

*Requirement 2(3)(a):*

A review of consumers’ care plans showed, for the most part, assessment and planning considered risks to their health and well-being, which was used to inform the delivery of safe and effective care and services. However, consumers who lived in the nursing home were subject to environmental restraint as they could not access one half of the wider service environment. Specifically, consumers’ access to the wider service was restricted as they were not given the code needed to open a secure door, nor could they leave the service without the code or staff assistance.

In addition, consumers subject to environment restraint did not have behavioural support plans in place to guide staff practice when caring for these consumers, nor had consent been given to apply a restrictive practice. The Assessment Team observed consumers attempting to exit the service independently but could not do so without staff assistance to unlock the door. Interviewed consumers said they would prefer to mobilise freely throughout the wider service environment.

During the Site Audit the Assessment Team shared consumers’ feedback with management, who advised all consumers subject to a restrictive practice would be reassessed with a goal to have all completed by October 2023. Management understood that consumers subject to a restrictive practice must have a behaviour support plan in place. I note the service had a new management team who commenced in late June 2023. Further, a new clinical manager was due to commence in late June 2033, which was after the Site Audit.

In its response of 2 August 2023, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance with a completion date of 31 December 2023. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 2(3)(a) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager, clinical care manager and registered nurses. Policies and procedures to be reviewed and remediated included, but were not limited to, care planning and assessment; service admission; validated care planning and risk assessment tools; freedom of choice; restrictive practice; behaviour support plans; documentation; medication management; and minimising the use of psychotropic medications.

While I acknowledge the Approved Provider has taken steps to remedy the deficiency, at the time of the site audit, consumers subject to an environmental restrictive practice had not given consent to apply the practice, nor were behaviour support plans in place. Therefore, I find the service was non-compliant with Requirement 2(3)(a) at the time of the site audit.

*The other Requirements:*

Consumers’ care plans identified and addressed their current needs, goals and preferences, which included end of life planning where they wished. The service partnered with consumers, their representatives and external service providers when assessing, planning and reviewing care needs. An analysis of care plans showed consumers participated in reviews which involved medical officers and allied health professionals.

The outcomes of assessment and planning were documented in consumers’ care plans which were readily available to consumers and those involved in their care. Consumers confirmed they had access to their care plans and consumers’ representatives were updated in person or by telephone when unable to visit the service. Consumers and representatives confirmed they were involved in regular care plan reviews and notified when incidents occurred or care needs changed. Consumers’ care and services were reviewed quarterly or following an incident which impacted their needs, goals or preferences.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | 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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 3(3)(a).

*Requirement 3(3)(a):*

The service did not demonstrate each consumer received safe and effective personal and clinical care that was best practice, tailored to their needs and optimised their health and well-being. Specifically, consumers were subject to environmental restrictive practice as they were not given the code needed to open a secure door, nor could they leave the service without a code or staff assistance. In addition, consumers had not given consent for environmental restrictive practice, nor were behaviour support plans in place for affected consumers and therefore, the service was not following best practice.

In its response of 2 August 2023, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance with a completion date of 31 December 2023. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 3(3)(a) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager, clinical care manager and registered nurses. Policies and procedures to be reviewed and remediated included, but were not limited to, best practice; access to latest information; continuous learning; feedback; care planning and assessment; and the charter of aged care rights.

While I acknowledge the Approved Provider has taken steps to remedy the deficiency, at the time of the site audit, the service was not following best practice as it related to consumers who were subject to an environmental restrictive practice. Therefore, I find the service was non-compliant with Requirement 3(3)(a) at the time of the site audit.

*The other Requirements:*

The service managed risks to consumers through clinical data monitoring, trending and applying individualised mitigation strategies for consumers, particularly for those with pressure injuries. Staff understood risks to consumers and described applicable management strategies, such as reassessing an individual’s mobility following a fall. Consumers were satisfied with how the service managed risks associated with their care.

A review of consumers’ care documentation showed their individual needs and preferences were recorded, along with their end of life wishes. Staff who provided palliative care described how consumers nearing the end of life were supported. For example, staff made consumers comfortable by repositioning, pain management and families were supported to spend time with their loved one. Changes in consumers’ conditions and care needs were responded to in a timely manner, which was confirmed by consumers, representatives and a review of care plans.

Consumers were satisfied with how changes to their conditions were communicated within the organisation and with others providing care. Staff received information about consumers’ conditions during shift handovers, progress notes and handover sheets. Consumers said referrals to other providers of care and services were timely, appropriate and occurred when needed, which was confirmed by a review of care plans. The service had processes in place to minimise infection-related risks and support the appropriate prescribing of antibiotics.

# Standard 4

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

Findings

The Quality Standard is assessed as Compliant, as seven of the seven specific requirements were assessed as Compliant.

Consumers confirmed they were supported to participate in activities they liked and which optimised their independence and quality of life. Lifestyle staff collected information about consumers’ likes, dislikes, personal interests and spiritual needs. Staff understood what was important to consumers and this aligned with information in care plans. Consumers confirmed they received the emotional, spiritual and psychological supports needed to maintain their well-being, such as attending religious services, receiving visits from church representatives and spending one-on-one time with staff.

Consumers participated in their community, did things of interest to them and were supported to maintain personal relationships. Consumers confirmed they could participate in activities such as visiting the local library, outings with the social support program, spending time with family inside and outside of the service and maintaining phone contact with loved ones. Consumers were satisfied with the quality, quantity and variety of food provided by the service. Consumers were offered meal options and could request an alternative if the menu was not to their liking. Consumers’ dietary needs and preferences were recorded in their care plans and understood by hospitality and care staff.

Where the service provided equipment, the Assessment Team noted it was safe, clean and well maintained. Consumers said they had access to mobility aids and other equipment which assisted them with activities of daily living. Care staff were responsible for cleaning shared equipment after each use and understood how to submit maintenance requests.

# Standard 5

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

Findings

The Quality Standard is assessed as Compliant, as three of the three specific requirements were assessed as Compliant*.*

*Requirement 5(3)(b):*

Consumers were satisfied with the cleanliness and maintenance of the service. Cleaning staff described the schedule they follow which included routine and spot cleaning. However, the Assessment Team considered the service environment did not enable consumers to move freely, both indoors and outdoors. Specifically, consumers could not access other parts of the service as they were not given the code needed to open a secure door, nor could they leave the service without a code or staff assistance.

In its response of 2 August 2023, the Approved Provider acknowledged the issues raised in the site audit report and advised of steps taken in response. Actions included a review and remediation of existing policies and procedures, which will be conducted by the facility manager, clinical care manager and registered nurses. Policies and procedures to be reviewed and remediated included, but were not limited to, restrictive practices and consumer involvement in decisions about the service environment.

Having considered the material in the site audit report and the Approved Provider’s response, I reached a different conclusion. I acknowledge that, as noted in other Standards, some consumers were subject to environmental restraint without proper consent and without behaviour support plans in place. However, that does not mean the service is non-compliant with this Requirement, as it is often necessary for a service to restrict access for certain consumers. Therefore, the simple presence of environmental restraint cannot mean a finding of non-compliance for this Requirement. Rather, to be compliant with the Requirement, a service must ensure that any restriction in place for consumers (such as environmental restraint) is based on the least restrictive option and that the basis for restraint is up-to-date, evidence-based and the reasons for the restraint are clear.

While I acknowledge the Approved Provider did not have consent in place for the environmental restraint, that issue has been appropriately considered under other Standards. The mere presence of environmental restraint does not indicate non-compliance and thus I find the service is compliant with Requirement 5(3)(b).

*The other Requirements:*

The service environment was welcoming, easy to understand and promoted a sense of belonging. Consumers felt at home within the service, particularly as they personalised their rooms with possessions of their choosing. Consumers were oriented to the service by staff and encouraged to decorate their space upon admission. The Assessment Team noted the interior environment was clean and designed with dementia-friendly principles in mind, including flat halls with accessible handrails and artwork to provide orientation throughout the service.

The service environment was safe, clean and well maintained. Staff described how the service was cleaned and maintained within a cleaning schedule. Maintenance staff conducted internal audits for cleaning and maintenance, including call bell checks. The Assessment Team reviewed maintenance records which showed all scheduled maintenance was completed.

# Standard 6

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

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 6(3)(d).

*Requirement 6(3)(d):*

The service did not demonstrate feedback and complaints were consistently used to improve the quality of consumers’ care and services. Whilst management described the processes in place to review feedback and complaints, there was no evidence to show information was recorded in a formal register. Management advised the feedback and complaints log could not be located due to multiple changes in service management. For context, previous management maintained a paper-based complaints system and, once located, new managers intended to enter the information into the electronic care management system and analyse complaints trends.

The Assessment Team reviewed the service’s continuous improvement plan which confirmed new managers had identified the paper-based feedback and complaints register was insufficient for recording, analysing and using the results to improve consumers’ care and services.

Notwithstanding the Assessment Team’s overall finding, I note consumers and representatives who had raised concerns were satisfied with improvements made in response to their feedback. For example, consumers asked for roast beef and gravy to be added to the Sunday lunch menu and this was done, to consumers’ satisfaction.

In its response of 2 August 2023, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance with a completion date of 28 February 2024. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 6(3)(d) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager. Policies and procedures to be reviewed and remediated included but were not limited to: complaints management; complaints mechanisms; and staff training in feedback management and use of the service’s electronic management system.

While I acknowledge the Approved Provider has taken steps to remedy the deficiency, at the time of the site audit, consumers’ feedback and complaints were not appropriately recorded and were not be used to improve the quality of care and services. Therefore, I find the service was non-compliant with Requirement 6(3)(d) at the time of the site audit.

*The other Requirements:*

Consumers and representatives were comfortable raising concerns directly with staff or management. Feedback and complaints could be made via consumer meetings and with a paper-based form. Information about how to make an internal or external complaint, provide feedback and access advocacy and interpreter services was available in the consumer handbook, brochures, on noticeboards throughout the service and from a visiting advocacy service. Staff understood their responsibilities in relation to complaints management and apologised to consumers when something went wrong.

# Standard 7

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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirements 7(3)(d) and 7(3)(e).

*Requirement 7(3)(d):*

The service did not demonstrate its workforce was recruited, trained, equipped and supported to deliver outcomes required by the Quality Standards. Specifically, only 26% of staff had completed mandatory training at the time of the Site Audit, with most training overdue by one year. In addition, the Assessment Team identified deficiencies in staff knowledge of restrictive practices and the Serious Incident Response Scheme (SIRS). The service’s administrative team were aware of staff training deficits and intended to advise management of the issue. A review of the service’s continuous improvement plan showed staff training deficits had not been recorded as an area for improvement.

In its response, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance, with an expected completion date of 28 February 2024. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 7(3)(d) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager, administration assistant and the workplace health and safety team. Policies and procedures to be reviewed and remediated included but were not limited to: recruitment; record keeping; role position descriptions; staff orientation and development; annual mandatory training and education; ad-hoc training; and agency staff training.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service was not supporting staff to deliver care in a way which met the Quality Standards. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 7(3)(d) at the time of the site audit.

*Requirement 7(3)(e):*

The service did not demonstrate it was regularly assessing, monitoring and reviewing the performance of its workforce. Specifically, the service did not have a performance management policy and interviewed staff could not describe the annual appraisal process, nor could they recall their last performance review. Management advised staff performance was monitored but could not provide an example staff appraisal that had been conducted in the previous year. In addition, a review of the staff performance appraisal register for 2023 showed only two of 12 eligible staff had participated in the process.

In its response, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance with a completion date of 28 February 2024. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 7(3)(e) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager. Policies and procedures to be reviewed and remediated included, but were not limited to, staff performance management; position descriptions; staff probationary period monitoring; ‘buddy’ shifts; and the code of conduct.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service was not regularly assessing, monitoring and reviewing the performance of its workforce in a way which met the Quality Standards. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 7(3)(d) at the time of the site audit.

*The other Requirements:*

Most consumers, representatives and staff confirmed there were sufficient staff at the service, though at times there was a shortage. However, consumers said there were no impact to the quality of care provided by staff. Management demonstrated the workforce was planned and adapted to ensure adequate staffing levels were available to meet consumers’ needs, which was confirmed by a review of relevant documentation.

Consumers and representatives confirmed staff were kind, caring and respectful when providing care and services. Staff were observed greeting consumers by their preferred name and were familiar with their individual needs and identities. All interviewed consumers and representatives were confident in staffs’ ability to meet their needs and said staff were effective in their roles.

# Standard 8

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| Organisational governance | | Non-compliant |
| 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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e).

*Requirement 8(3)(a):*

Whilst consumers said they were supported to provide feedback and make complaints, the service did not demonstrate consumers were given additional opportunities to engage in the development, delivery and evaluation of their care and services. A review of documentation showed consumers had not participated in a survey for two years and case conferences were not regularly conducted. Further, the service’s continuous improvement plan showed complaints were not being monitored and analysed to ensure consumers’ feedback could inform a continuous improvement process.

In its response, the Approved Provider acknowledged the issues in the site audit report and advised it had taken steps to remedy the non-compliance, with an expected completion date of 28 February 2024. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 8(3)(a) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager and governing body. Policies and procedures to be reviewed and remediated included but were not limited to: resident and representative meetings; consumer experience survey; care plan reviews and case conferences; and consumer involvement in development and redesign projects.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service was not providing adequate opportunities for consumers to engage in the development, delivery and evaluation of their care and services. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 8(3)(b) at the time of the site audit.

*Requirement 8(3)(b):*

The service did not demonstrate the organisation’s board of directors (the board) promoted a culture of safe, inclusive and quality care and services for which it was accountable. The service was not reporting areas for improvement to the board, which as a group did not provide adequate oversight of the service’s performance against the Quality Standards. Specifically, the board was not monitoring clinical indicators, complaints, continuous improvement opportunities, policies for review and staff training levels.

In its response, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance, with an expected completion date of 28 February 2024. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 8(3)(b) of the Quality Standards.

Actions taken to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager and governing body. Policies and procedures to be reviewed and remediated included, but were not limited to, emergencies, disasters and infection control; quality management; governance and risk; clinical governance; business continuity plan; governance meeting minutes; strategic, business and diversity action plan; clinical indicator reporting; and the code of conduct.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service’s governing body did not promote a culture of safe, inclusive and quality care and services for which it was accountable. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 8(3)(b) at the time of the site audit.

*Requirement 8(3)(c):*

The service had mechanisms in place for effective financial governance. However, the service did not demonstrate it had effective organisation wide governance systems for information management, workforce governance, regulatory compliance and feedback and complaints. Specifically, the service had policies which were not being followed by staff and in addition, the documents required review.

In its response of 2 August 2023, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(c), and advised it had taken steps to remedy the non-compliance with a completion date of 28 February 2024. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 8(3)(c) of the Quality Standards.

Actions taken to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager and governing body. Policies and procedures to be reviewed and remediated included but were not limited to: workforce governance; information management; regulatory compliance, privacy and confidentiality; food safety; infection outbreak management; performance monitoring; and record keeping and reporting.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service did not demonstrate it had effective organisation wide governance systems for information management, workforce governance, regulatory compliance and feedback and complaints. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 8(3)(c) at the time of the site audit.

*Requirement 8(3)(d):*

Most consumers confirmed the service supported them to live their best lives. However, the service’s risk management system was ineffective in preventing and responding to incidents, including the escalation of incidents to ensure each was appropriately reviewed. The Assessment Team reviewed the roles and responsibilities clauses of the incident management policy and noted both were blank.

The service did not have a policy to guide staff in identifying and responding to the abuse of consumers, nor how to internally escalate issues. With respect to managing high-impact and high-prevalence risks associated with the care of consumers, the service did not demonstrate consumers’ changed behaviours were appropriately managed.

In its response of 2 August 2023, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(d), and advised it had taken steps to remedy the non-compliance with a completion date of 31 December 2023. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 8(3)(d) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager, clinical care manager and registered nurses. Policies and procedures to be reviewed and remediated included but were not limited to: effective incident management; staff training in recognition and documentation of risk; managing high-risk and high-prevalence risk; identification of abuse and neglect; escalating and reporting abuse and neglect; risk mitigation; open disclosure; restraint management; incident data analysis and trending; and the SIRS. In addition, staff will be trained in the abovementioned policies to be reviewed and remediated.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service’s risk management systems were ineffective. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 8(3)(d) at the time of the site audit.

*Requirement 8(3)(e):*

The service did not demonstrate its clinical governance framework supported the monitoring of consumers who were subject to a restrictive practice. The Assessment Team noted audits were not occurring, the restrictive practice register did not include consumers subject to a restrictive practice and reviews of progress notes were not conducted. The service could not show where restrictive practices had been applied only as a last resort. In addition, clinical meetings were not being held, deficits in staff practice were not identified and therefore, were not included in the service’s plan for continuous improvement.

In its response, the Approved Provider acknowledged the issues raised in the site audit report and advised it had taken steps to remedy the non-compliance, with an expected completion date of 31 December 2023. The response was brief and did not include documented evidence in support of actions taken to return the service to compliance with Requirement 8(3)(e) of the Quality Standards.

Actions take to address the non-compliance included a review and remediation of existing policies and procedures, which will be conducted by the facility manager, clinical care manager and registered nurses. Policies and procedures to be reviewed and remediated included, but were not limited to, the clinical governance framework; reporting incidents and risks to the board; clinical performance indicators and data collection; medication advisory committee; staff training in open disclosure; antimicrobial stewardship; and the use and authorisation of restrictive practices.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the site audit the service’s clinical governance framework did not support the monitoring of consumers who were subject to a restrictive practice. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 8(3)(e) at the time of the site audit.

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