Performance

Report

**1800 951 822**

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| Name of service: | Mandalay Retreat |
| Service address: | Crn Bay and Wellington Streets CLEVELAND QLD 4163 |
| Commission ID: | 5350 |
| Approved provider: | Senjah Pty. Ltd. |
| Activity type: | Site Audit |
| Activity date: | 25 October 2022 to 27 October 2022 |
| Performance report date: | 30 November 2022 |

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 Mandalay Retreat (**the service**) has been prepared by T Wurf, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others, and
* other information and intelligence held by the Commission.

# Assessment summary

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

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

# Areas for improvement

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

# Other relevant matters:

The Performance Report dated 24 September 2021 following a site audit undertaken from 6 to 9 July 2021 found the service non-compliant with 15 requirements across six of the Quality Standards:

* Requirement 1(3)(a)
* Requirement 2(3)(e)
* Requirements 3(3)(a), 3(3)(b), 3(3)(g)
* Requirements 5(3)(b), 5(3)(c)
* Requirements 6(3)(c), 6(3)(d)
* Requirements 7(3)(a), 7(3)(d)
* Requirements 8(3)(b), 8(3)(c), 8(3)(d), 8(3)(e)

An unannounced assessment contact was undertaken on 13 April 2022 to reassess requirements 1(3)(a), 3(3)(g), 5(3)(b) and 5(3)(c) and these were found compliant, as detailed in the Performance Report dated 16 May 2022.

# Standard 1

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

Findings

Consumers said staff treat them with dignity and respect, value their culture and diversity and provide culturally safe care. Consumers are supported to nominate whom they would like involved in their care, communicate their decisions, make connections with others and maintain relationships of choice. Consumers were confident their information is kept confidential and said staff respect their privacy.

Consumers discussed how the service supports them to take risks, such as smoking and independently accessing the local community. Staff described how consumers are supported to understand the benefits and possible harm when they make decisions about taking risks, and how consumers are involved in discussions about strategies to manage risks.

Consumers were satisfied with the range of information provided to them by the service and described various topics and formats in which information is provided. They said timely and relevant information provided supported their decision-making, including about activities, meals, special events and COVID-19.

Staff understood consumers’ individual choices and preferences and described how they adapt the care they deliver to ensure individual consumers feels valued and safe. Staff explained how consumers are supported to maintain relationships of choice through receiving visitors to the service, utilising video calls, undertaking outings to visit friends and family, and attending the service’s group activities.

Care planning documents were individualised, reflected what was important to consumers and included information about their backgrounds, personal and community relationships, life experiences, interests and religious preferences.

The Assessment Team observed staff treating consumers respectfully, conducting shift handover in private areas and ensuring computers were password locked when not in use.

The organisation has policies and processes relevant to this Quality Standard, including in relation to respect and dignity, and choice and decision-making.

# 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

Consumers and their representatives reported they are involved in, and are satisfied with, the assessment and care planning processes at the service. They reported that the service communicates outcomes of assessment and planning, including during regular care plan reviews, and when changes occur. Consumers said staff discuss their care with them and they have access to their care plan if they wish.

Registered staff described the service’s assessment, care planning and review process. Management described how consumers and representatives are involved in case conferences and six-monthly care plan reviews, which can also include other health professionals. Staff advised they have access to consumers’ care plans via the electronic care management system and information shared at shift handover. Staff understood incident reporting processes and how these incidents may trigger a reassessment or review.

The service’s assessment and planning processes identified consumers’ goals and preferences, including in relation to advance care planning and end of life care. Care documentation reflected consideration of potential risks to consumers’ health and wellbeing, including in relation to specialised nursing care, diabetes management and skin integrity, and strategies to manage identified risks. Consumers’ care documentation evidenced the involvement of the consumer and their representatives and other health professionals such as medical officers and allied health professionals. Care documentation was readily available to staff.

The organisation has policies and procedures that guide staff in assessment and planning.

I am satisfied the service has taken improvement actions to address non-compliance identified under requirement 2(3)(e) as outlined in the Performance Report dated 24 September 2021. It is my decision this requirement is now compliant. Actions included:

* Reviewed and updated behaviour support plans to include recommendations from external specialists.
* Established weekly pain management meetings with the clinical manager and registered staff to discuss consumers receiving pain medication and/or interventions to ensure pain management is effective and appropriate.
* Implemented alerts for when care planning reviews are due and when a change in a consumer’s condition requires review.
* Introduced a paper-based case conference record that is completed by registered staff and reviewed by the clinical manager.

Based on the findings contained in the site audit report and the improvements made by the service, it is my decision that each requirement and the overall quality standard 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

Consumers and representatives provided positive feedback about the care provided at the service and were confident that the staff understood their needs and preferences.

Staff demonstrated detailed knowledge of consumers’ care needs and the processes to support care delivery. Staff described the use of handovers to share information about consumers.

The Assessment Team reviewed consumers’ care documentation, including those with complex care needs, and found:

* evidence of effective care delivery including in relation to the management of wounds, pain, changing behaviours, diabetes, medication administration and restrictive practices
* clinical risks were identified, managed and reviewed
* deterioration or changes in condition were recognised and responded to
* for those consumers approaching end of life, palliative care plans included details about the consumers’ preferences and reflected the involvement of a medical officer and the consumers’ representative. Staff are guided by palliative care pathways and demonstrated an understanding of processes to support consumers nearing the end of life
* referrals were made to health care specialists where required, including dietitians, physiotherapists, speech pathologists, and wound specialists; and
* monitoring and clinical oversight were evident in clinical records, incident reports, training records, handover and clinical indicator data maintained by the service.

The service has policies and procedures to guide staff practice in relation to personal and clinical care, including wound management, skin integrity and restrictive practices.

The service has policies, procedures and outbreak management plans to ensure infection-related risks are minimised. The service has practices to promote the evidence-based use of antibiotics. The service has a dedicated infection control and prevention lead and provides a vaccination program for staff and consumers. Staff received training in infection prevention and control. The Assessment Team observed staff using personal protective equipment and performing hand hygiene appropriately.

I am satisfied the service has taken improvement actions to address non-compliance identified under requirements 3(3)(a) and 3(3)(b) as outlined in the Performance Report dated 24 September 2021. It is my decision these requirements are now compliant. Actions included:

* A new documented handover sheet that contains critical daily information provided to care staff in addition to the daily verbal handover meeting that occurs between care staff and registered staff.
* Care plan reviews are completed regularly by registered staff and include reviews of consumers’ behavioural support plans to ensure strategies are effective.
* In relation to pain management:
  + daily pain charting is completed for consumers on regular opioids
  + weekly pain management meetings are held to review consumers who have had changes in pain management or where pain management has not been effective and
  + monthly pain management audits and reviews are completed by the clinical manager.
* In relation to falls management:
  + falls management flow charts are displayed in nurses’ stations to guide staff practice and
  + consumers who experience a fall have pain charting and neurological observations, in accordance with the falls management policy and procedure.

Based on the findings contained in the site audit report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

# Standard 4

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

Findings

Consumers said the service’s lifestyle and activities program supports their lifestyle preferences and staff assist them to be as independent as possible. Consumers provided examples of the activities they enjoy both within and outside the service; including spending time with friends, shopping, concerts, bus outings or pursuing a previous interest. Consumers sampled said they were satisfied with the ways the service assists them to access spiritual support, interact with their families and friends and access internal and external activities which support their emotional well-being. Some consumers described how they have been supported through the provision of church services, volunteers and therapy dogs. Consumers are supported to keep in touch with people who are important to them and maintain community connections through visits from religious figures, volunteers, and local entertainers.

Staff demonstrated knowledge of consumers’ individual needs, goals and preferences and the support they require to participate in activities or pursue individual interests. Staff explained changes in a consumer’s condition, needs or preferences are communicated via shift handover and the electronic care management system. Staff explained the ways in which they supported consumers to access spiritual and emotional support.

Care documentation reflected the need, goals and preferences of consumers in respect of services and supports for daily living, and specific individualised strategies to deliver these. Documentation identified the people important to individual consumers and those involved in providing activities of interest to the consumer. The service makes timely referrals to, and collaborates with, other individuals, organisations and providers to meet the diverse needs of consumers, including local church and community groups, yoga instructors, a mobile library, and the Community Visitor Scheme.

Consumers said the food provided was tasty, fresh, and sufficient in size and there was enough choice and variety to satisfy their needs. Care documentation reflected each consumer’s dietary preferences and needs and noted allergies and contraindications for types of food. Menu options are determined with consumer input and have dietician oversight to ensure the food is nutritious and appropriate for each individual consumer.

Consumers said the equipment available to them is safe and they know how to report any concerns or issues. The service has processes for purchasing, servicing and replacing equipment. Scheduled and non-scheduled maintenance is actioned promptly. The Assessment Team observed equipment used to support consumers to engage in lifestyle activities to be suitable, clean and well-maintained.

# Standard 5

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

Findings

The service is welcoming, has wide corridors with handrails, several large communal areas where consumers can meet with friends and family, an onsite hairdresser, a chapel, a cinema, and spacious outdoor garden areas. The service also has a courtyard attached to its memory support unit which includes gardens and an undercover area with outdoor furniture. Consumers’ rooms are spacious and have been personalised with items reflecting their individual tastes and styles. The service has signage and maps of the buildings available in various locations throughout the service.

Consumers reported they are able to move freely around the service and socialise with others in communal areas. The Assessment Team observed consumers in the memory support unit moving freely inside and in the outdoor courtyard and garden areas.

Furniture, fittings and equipment were observed to be well maintained, clean and safe. Cleaning and maintenance are scheduled and monitored daily by staff. Maintenance issues or cleaning required are reported and resolved in a timely manner.

# Standard 6

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

Findings

Consumers and their representatives said they feel encouraged, safe and supported to make a complaint or provide feedback to the service and consistently described management as approachable. They identified various avenues available to them to raise feedback and complaints. Management and staff described mechanisms available to consumers/representatives should they wish to provide feedback or make a complaint. Management identified the process to document feedback and complaints in the complaints register. Staff described their role to support and encourage consumers to provide feedback.

Consumers were aware of how to make complaints to external organisations and how to access advocacy services should they wish to do so. Management and staff described how the service promotes advocacy and language services in the monthly newsletter, at consumer/representative meetings, and information display throughout the service.

Consumers/representatives who had made a recent complaint said management acknowledged the issue and involved them in the process to resolve their complaint. Representatives confirmed timely and appropriate action was taken in response to the concerns raised. Representatives and management provided examples of where the service had practised open disclosure.

The service maintains a feedback and complaints register that records feedback and complaints received, actions taken and outcomes. Complaints, feedback and survey data are trended and analysed by management. The service uses feedback and complaints to inform improvement activities, and these are documented in the service’s plan for continuous improvement. Consumers and representatives discussed recent improvements made as a result of feedback and complaints including to meal options and alerts in the electronic care management system to ensure representatives are consulted on certain matters.

I am satisfied the service has taken improvement actions to address non-compliance identified under requirements 6(3)(c) and 6(3)(d) as outlined in the Performance Report dated 24 September 2021. It is my decision these requirements are now compliant. The service has undertaken a range of improvement actions, including:

* Implemented a new complaints register where all complaints received verbally, in writing or via feedback forms are documented, along with complaint management information such as date/time and source of the complaint, date/time of response and resolution and outcome of the complaint. The register is monitored by management.
* Established new mechanisms for consumers to provide feedback, including consumer/representative surveys and food focus meetings
* Results of consumer surveys, food focus groups and consumer/representative meetings requiring actions are tabled at management meetings and entered into the service’s plan for continuous improvement.
* Improvements implemented by the service as a result of consumer/representative feedback and complaints are published in the service’s newsletter and discussed at consumer/representative meetings.
* Feedback and complaints are trended and reported at management, clinical governance and Board meetings.

Based on the findings contained in the site audit report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

# Standard 7

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

Findings

Consumers said that staff treat them well and are kind and caring. Overall, consumers said that staff are available when they need them and are responsive to their calls for assistance. Consumers expressed confidence that staff know what they are doing and have relevant knowledge, skills and training to perform their roles.

Staff reported that whilst the service can be shorted staffed, agency staff are utilised to fill shifts. Management described the service’s mix of registered and care staff, strategies to replace staff on planned and unplanned leave, and the ongoing recruitment processes. Management advised call bell response times are monitored daily and reported monthly at consumer, staff and Board meetings.

The service has role-specific position descriptions which establish knowledge, skills, and qualifications, and processes to monitor these. New staff receive orientation and buddy shifts, followed by ongoing support and supervision. Staff receive training relevant to their roles and all staff had completed mandatory training. Where staff have not completed training, they are supervised by registered staff. Agency staff confirmed they had received orientation and are provided with detailed consumer information on each shift. Staff performance and interactions with consumers are regularly monitored through observations, surveys, audits, analysis of clinical data, review of clinical records and care delivery, and consumer/representative feedback. Performance reviews occur annually, and the service has a process to track the completion of these.

The Assessment Team observed staff interacting with consumers respectfully and in a kind and caring manner.

The service has policies in relation to consumer dignity and respect and diversity and inclusion. Information about the Aged Care Quality Standards and Charter of Aged Care Rights is displayed on noticeboards around the service and included in the staff handbook.

I am satisfied the service has taken improvement actions to address non-compliance identified under requirements 7(3)(a) and 7(3)(d) as outlined in the Performance Report dated 24 September 2021. It is my decision these requirements are now compliant. Actions included:

* Increased agency staff to supplement the service’s workforce and ensure sufficient staff are available to meet consumers’ needs.
* Including workforce planning and staff recruitment and retention as standing agenda items on staff, management and Board meetings.
* Appointed a clinical manager responsible for managing and tracking staff training and education.
* Staff training and information about the serious incident response scheme (SIRS), including resources and flowcharts are available to staff.
* Duty statements provided to staff during orientation that detail staff responsibilities relevant to their role.
* Various improvements to the orientation process and agency staff orientation checklist.

Based on the findings contained in the site audit report and the improvements made by the service, it is my decision that each requirement and the overall quality standard 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

Consumers considered the service is well run and they can provide feedback and suggestions to management which are considered. Management described various ways consumers are supported to be engaged in the development, delivery and evaluation of care and services, such as via feedback and complaints, monthly consumer meetings, food focus meetings, and annual surveys.

The organisation’s governance framework identifies a leadership structure with the governing body holding overall accountability for quality and safety. This service now has a clinical governance framework and organisational values. The Board meets monthly with the management of the organisation’s services and receives and reviews information on clinical and incident data/trends analysis, operational and financial information, and risk reporting. The Board uses this information to identify the service’s compliance with the Quality Standards, to enhance performance and mitigate risks, and to monitor and take accountability for care and service delivery.

Management described the various ways in which the organisation communicates with consumers/representatives and staff regarding updates on policies, procedures or changes to legislation.

The organisation implemented various actions and improved its governance systems relating to information systems, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints. These systems are now effective.

The service has established governance frameworks, policies and procedures to support the management of risk associated with the care of consumers, including responding to clinical incidents. The service has an incident management system and policies and procedures in relation to incident reporting. Staff have received training and understand their responsibilities to report incidents. Severe incidents are communicated to the Board.

The organisation has a documented clinical governance framework, and policies relating to antimicrobial stewardship, minimising the use of restrictive practices and open disclosure. Staff said these policies had been discussed with them and were able to explain what they meant in a practical way.

I am satisfied the service has taken improvement actions to address non-compliance identified under requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) as outlined in the Performance Report dated 24 September 2021. It is my decision these requirements are now compliant. The service has undertaken a range of improvement actions, including:

* The structure and processes around Board and management meetings have been formalised and these meetings are minuted.
* A monthly clinical governance meeting was established in October 2021 whereby the organisation’s clinical managers meet with a Board Director to discuss strategies and management of clinical care.
* Introduction of a new clinical governance framework in November 2021 that identifies a leadership structure and overall responsibility of the governing body, and includes a set of organisational values.
* Improved governance systems:
  + by ensuring staff access to policies and procedures and consumer assessment and care planning documentation, staff receive mandatory and relevant training
  + by establishing an effective plan for continuous improvement which includes consumer feedback and incidents and is managed by the service’s clinical manager and facility manager
  + in relation to budgeting and expenditure
  + by updating the consumer handbook to ensure consistency with relevant legislation and
  + in relation to feedback and complaints and workforce governance as outlined above in Standards 6 and 7.
* Updated the service’s risk management plan to reflect risk identification and management strategies, and made available to staff procedures to guide the management of high impact and high prevalence risks.
* Staff education and information on incident management and the Serious Incident Response Scheme.

Based on the findings contained in the site audit report and the improvements made by the service, it is my decision that each requirement and the overall quality standard are compliant.

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