Performance

Report

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| Name of service: | McLean Care Mackellar Alkira Campus |
| Service address: | 35 - 45 Marquis Street GUNNEDAH NSW 2380 |
| Commission ID: | 0354 |
| Approved provider: | McLean Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 to 12 July 2023 |
| Performance report date: | 31 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 McLean Care Mackellar Alkira Campus (**the service**) has been prepared by G Cherry, 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 - Site; the Assessment Contact - 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 9 August 2023 including a plan for continuous improvement.
* Performance Report dated 6 July 2022
* Non-Compliance Notice dated 4 August 2022

# 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 | 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 | Not applicable as not all requirements have been assessed |

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)(b) | Care and services are culturally safe | Compliant |

Findings

The Quality Standard was not fully assessed; one of six requirements was assessed and found compliant.

A decision was made on 6 July 2022 the service was non-compliant in requirement 1(3)(b) following a Site Audit conducted from 10-17 May 2022 as the service did not demonstrate information relating to cultural identity/beliefs, practices and preferences relating to consumers’ backgrounds is included in their care planning documentation to inform care delivery. In response, multiple changes have occurred including gathering data of consumer’s social, cultural, lifestyle backgrounds and ensuring accurate documentation; conducted a survey to ascertain satisfaction, implementation of cultural identity register to ensure ready access and several staff education/training sessions; updated admission procedure to ensure appropriate information gathered. Appointment of a Cultural Safety and Diversity Champion role has been developed and successful applicant appointed; implementation of a Diversity Framework/action plan engagement with Centre of Cultural Diversity and Ageing.

During this assessment contact information was gathered through interviews, observations, and document review. Effective systems to ensure provision of culturally safe care and services is evident. Consumers express satisfaction in receipt of culturally safe care and services. Document review for sampled consumers detail individual information relating to life history, cultural, religious, and spiritual needs. Interviewed management and staff demonstrate knowledge of each consumer’s cultural identity, respecting diversity and how they provide inclusive care and support and deliver care in accordance with consumer’s cultural needs/preferences.

I find requirement 1(3)(b) is 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

All requirements of this Quality Standard were assessed and found compliant.

A decision was made on 6 July 2022 the service was non-compliant in all five requirements following a Site Audit conducted on 10-17 May 2022.

Requirement 2(3)(a)

Previously the service did not demonstrate assessment and planning (including consideration of risks to the consumer’s health/well-being) is completed in a timely manner, nor risks assessed on an ongoing basis to deliver safe/effective care. In response, the following improvements were demonstrated. Review of consumer assessment/care planning documentation and amendment/update where required; admission procedure reviewed/updated; redevelopment of care management software to include live compliance score for oversight; regular ongoing monitoring processes and reporting (escalation when consumer’s condition changes; staff education relating to risk management electronic system; policy/procedures documentation updated and survey conducted in relation to consumer satisfaction of care planning/case conference discussion.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrates effective systems to consistently identify/address consumers’ needs/preferences in care planning documentation. Organisational policies/procedures guide staff practice of conducting assessment/care planning and documentation requirements. Sampled consumers files demonstrate care planning directives which address specific risks to the consumer's health and well-being and inform delivery of safe and effective care and services. I find requirement 2(3)(a) is compliant.

Requirement 2(3)(b)

Previously the service did not demonstrate assessment/care planning is reviewed when consumer’s condition change to identify/address current needs/goals/preferences, including advance care and end of life planning. In addition to actions detailed in requirement 2(3)(a), improvements include: ELDAC project implemented to support palliative and advance care planning processes/practices; implementation of a palliative care committee/meeting schedule’ policies/procedures updated to ensure consistency with Advance Care Planning Improvement (ACPI) Toolkit; development of advance care directive register/review schedule to monitor ongoing currency/accuracy of directives; communication with consumers/representatives via multiple methods to address specific concerns and transition of case conference documentation to new electronic care management system. Ongoing monitoring processes demonstrate continued consumer partnerships, and consumer/representative awareness/receipt of documentation.

During this assessment contact information was gathered through interviews, observations, and document review. Reviewed consumer’s documentation consistently addresses areas of care and services and contain individual preferences/current needs. Sampled consumers/representatives express positive feedback in relation to their needs/preferences being met, noting opportunities to discuss end of life care and specific wishes. Interviewed staff demonstrate knowledge of consumers current needs/preferences and for consumers. I find requirement 2(3)(b) is compliant.

Requirement 2(3)(c)

Previously the service did not demonstrate care consultation (based on ongoing partnership with consumers/and others of their choice) is regularly conducted, including when changes occur. In response, improvements have been made as detailed in requirements 2(3)(a) and 2(3)(b).

During this assessment contact information was gathered through interviews, observations, and document review. Effective processes ensure assessment and planning is based on ongoing partnerships with consumers, those they wish to be involved, and other organisations/ providers of care provision. Documentation review detail evidence of case conference discussions, consumer engagement and involvement of a range of other health providers such as dietitians, speech pathologists and wound consultants. Sampled consumers/representatives consider involvement in care planning discussions, provision of care planning documentation and satisfaction needs are met. I find requirement 2(3)(c) is compliant.

Requirement 2(3)(d)

Previously the service did not demonstrate assessment/care planning outcomes are effectively communicated and documented in care plans readily available to consumers. In response, improvements have been made as detailed in requirements 2(3)(a) and 2(3)(b).

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate outcomes of assessment and planning are effectively communicated to consumers/representatives and documented in care plans readily available consumers, and others where care and services are provided. Care and service documentation showed discussions around care have been occurring. Sampled consumers/representatives’ express satisfaction of involvement in discussions/meetings and provided with a copy of their care plan. Interviewed staff explained awareness of involving/updating consumers/representatives. I find requirement 2(3)(d) is compliant.

Requirement 2(3)(e)

Previously the service did not demonstrate care and services are reviewed for effectiveness when circumstances change, or when incidents impact consumer’s needs/preferences.

In addition to actions detailed in requirements 2(3)(a) and 2(3)(b) improvements include: Incident Management Policy and SAC rating matrix updated to support clinical practice; ongoing monitoring processes demonstrate care plan reviews are occurring as per schedule; provision of education to senior staff in relation to effective incident management/clinical review expectations plus design/introduction of clinical incident performance dashboard providing live information regarding incident status/performance measures.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate comprehensive review of care and services is conducted for effectiveness when circumstances change, and/or incidents impact consumers’ needs/preferences. Sampled consumers/representatives’ express satisfaction of being informed of changes, and documentation detail amendment to reflect changes and demonstrate currency. Care documentation and incidents inform review, and monitoring processes ensure compliance with organisation requirements. I find requirement 2(3)(e) is 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 |

Findings

The Quality Standard was not fully assessed. Six of seven requirements were assessed and found compliant.

A decision was made on 6 July 2022 the service was non-compliant in requirement six of the seven requirements following a Site Audit conducted on 10-17 May 2022.

Requirement 3(3)(a)

Previously the service did not demonstrate systems to ensure pain, medication management, and skin integrity align with principles of best practice, are routinely assessed and/or monitored to ensure consumers receive safe/effective personal care and clinical care. In response, improvements have been made including review of consumer assessment/care planning documentation and amendment/update where required in relation to pain, provision of staff education regarding effective recognition/recording/monitoring of pain symptoms; daily monitoring by registered nurses to ensure immediate pain management interventions implemented as required; reassessment of all consumers via updated care management software to effectively assess pain using best practise assessment tools; implementation of ‘Painchek’ module to support early recognition and consistent assessment of pain; design/introduction of clinical incident performance dashboard to provide daily live information following incidents to ensure holistic pain management; clinical review of all consumers (undertaken by senior clinician) to ensure appropriate administration of ‘as required’ (PRN) medication; provision of staff education/competency assessment; monitoring processes to ensure appropriate administration of medication as per pharmacy directives; transfer of pharmaceutical support contract to alternative pharmacy and regular reporting to executive team regarding medication incidents/corrective actions.

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives’ express satisfaction with care and services while 3 expressed dissatisfaction, 1 citing lack of responsiveness to requests for attention relating to personal hygiene care and mobility assistance, 1 consumer’s hearing/vision needs not addressed resulting in frustration and 1 citing lack of access to medical services affected their health needs and lack of staff cleaning oxygen equipment. Demonstration of appropriate pain management strategies is mostly evident although a lack of documented response for 1 consumer, timely referral/management of unplanned weight loss and appropriate strategies for ensuring skin integrity/wound management (including use of products deemed practice), however consistent wound measurement details is lacking. Via review of 3 consumer’s documentation the assessment team note staff not adhering to appropriate neurological observation post falls.

Appropriate recording/monitoring processes relating to restrictive practices is generally evident, and the service demonstrates consultation and informed consent obtained prior to use of most restrictive practices. However, the assessment team note recent locking of a door (to prevent 1 consumer from leaving the service) impacted other consumers ability to freely exit, plus interview with staff and review of documentation note ongoing unmet behaviours not addressed. While consultation occurred with consumers/representatives, appropriate processes were not implemented; management committed to researching alternative methods to address this issue and immediately ensured free consumer access.

The approved provider, in their response supplied evidence of updated falls management procedure to alert staff in relation to anticoagulant medication/appropriate incident management documentation, immediate provision of staff education/training (plus planned training relating to wound management), consultation with named consumers to ascertain satisfaction, monitoring of reported incidents to ensure appropriate completion of neurological observations, and dietitian review in relation to unplanned weight loss for 1 consumer. In relation to inappropriate locking a door they provided education to leadership team and staff, implemented a new organisational perimeter restraint assessment tool, communicated with consumers/representatives in relation to breach of regulatory requirements and committed to ongoing monitoring by organisational management team to ensure compliance. While I acknowledge immediate actions implemented once bought to the leadership team’s attention, and accept practice is in breach of organisational expectations, I am concerned ineffectiveness of previous staff education/training to ensure knowledge of legislative requirements and organisational monitoring systems did not self-identify compliance deficit.

In consideration of compliance, I accept immediate responsive actions, plus re-education staff training, and the approved provider’s commitment to ongoing organisational led monitoring processes to safeguard against re-occurrence.

I find requirement 3(3)(a) is compliant.

Requirement 3(3)(b)

Previously the service did not demonstrate systems to ensure management of high impact/prevalence risks associated with each consumer care include mitigation strategies which are regularly reviewed to minimise reoccurrence. In addition to actions detailed in other Standard 3 requirements, improvements include: implementation of software to facilitate organisational oversight of all reported incidents; provision of staff education in relation to use of software; appointment of clinical governance quality and risk coordinator to support daily oversight of all clinical incidents; updated incident management policy; design/introduction of clinical incident performance dashboard to provide live information regarding incident status/performance measures and regular reporting to CEO of clinical incident.

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives consider risks associated with consumer’s individual care are addressed. Review of risk management documentation detail processes to ensue incidents are investigated and interventions implemented to prevent reoccurrence; organisational staff support service management team in oversight of clinical incidents. Interviewed staff demonstrate knowledge of organisational requirements. Via document review the assessment team note details relating to anticoagulant therapy not considered as a potential risk relating to falls management. Management advised appropriate recording and consideration would occur in management of future incidents.

In their response, the approved provider supplied evidence of updated falls management procedure to alert staff in relation to anticoagulant medication/appropriate incident management documentation plus immediate provision of staff education/training.

I find requirement 3(3)(b) is compliant.

Requirement 3(3)(c)

Previously the service did not demonstrate systems to ensure consumer’s needs/preferences when nearing end of life are recognised/addressed. In addition to actions detailed in other Standard 3 requirements, improvements include: review and update of Palliative Care Policy’ to support staff practice and implementation of Advanced Care Planning Improvement toolkit, introduction of palliative care committee, development of advanced care directive register and monitoring process to ensure accuracy, implementation of End of Life Directions for Aged Care project to support palliative care and advanced care planning practices and review of care.

During this assessment contact information was gathered through interviews, observations, and document review. Overall, consumers/representatives consider involvement in appropriate advanced care planning and consumers end of life wishes known by staff. Interviewed staff described changes in care provision as consumers approach end of life. Documentation detail specific advanced care plans/wishes guide care provisions relating to pain relief, regular medical officer review, comfort cares and consumer’s specific requests. I find requirement 3(3)(c) is compliant.

Requirement 3(3)(d)

Previously the service did not demonstrate systems to ensure deterioration/change in consumer’s mental health/cognitive/physical function, capacity or condition is recognised/responded to in a timely manner. In addition to actions detailed in other Standard 3 requirements, improvements include: provision of staff education in relation to early detection of deterioration in the elderly (EDDIE), flow chart and escalation of care process; implementation of remedial education in relation to ISBAR (Identify, Situation, Background, Assessment, Recommendation) to support consistency in communication with medical officers.

During this assessment contact information was gathered through interviews, observations, and document review. Most consumers/representatives consider staff appropriately address change/deterioration to consumers condition, giving examples of care provided. Representatives’ express satisfaction of being informed of changes. Examples of referral to medical officer, allied health and other specialists is evident. Management was observed communicating with consumers and monitoring for changes in condition. I find requirement 3(3)(d) is compliant.

Requirement 3(3)(e)

Previously the service did not demonstrate systems to ensure consumer information is documented/communicated with those where responsibility of care is shared. In addition to actions detailed in other Standard 3 requirements, improvements include: provision of staff education/training; implementation of clinical handover process (and documentation); design/implementation of information guidance to assist staff in identifying when referral required; appointment of clinical governance quality and risk coordinator to support identification of trends/referrals; monitoring processes including reports to senior management team.

During this assessment contact information was gathered through interviews, observations, and document review. Overall, sampled consumers/representatives gave feedback information relating to consumer’s condition, needs/preferences are documented/communicated with those who are involved in care provision. The service demonstrates processes to ensure information is effectively communicated with all at the service and health practitioners who share consumer care. The assessment team observed comprehensive clinical discussions occurring between staff detailing recent incidents and daily events requiring follow up. Registered nurses’ direct completion of specific cares required. Review of documentation detail medical officer, allied health assessments, directives to guide staff in care provision. I find requirement 3(3)(e) is compliant.

Requirement 3(3)(f)

Previously the service did not demonstrate systems to ensure timey referrals to organisations and providers of care/services.

In addition to actions detailed in other Standard 3 requirements, improvements include: introduction of referral register to ensure ease of oversight in monitoring outstanding/ upcoming referral dates. During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives consider appropriate referral to medical officers/specialists occurs when required, including input from allied health services. Consumer documentation detail referrals occur in a timely manner. I find requirement 3(3)(f) is 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 |

Findings

The Quality Standard was not fully assessed. Three of five requirements were assessed and found compliant.

A decision was made on 6 July 2022 the service was non-compliant in requirements 7(3)(a), 7(3)(b), and 7(3)(c) following a Site Audit conducted on 10-17 May 2022.

Requirement 7(3)(a)

Previously the service did not demonstrate sufficient and appropriate numbers of staff to meet consumers’ clinical care needs and clinical oversight relating to provision of personal care and assistance with consumers nutrition/hydration requirements. In response, improvements include: development of a workforce strategy (targeted campaigns) to attract/retain staff, partnership with industry associations to facilitate registered nurse enrolment in training programs; monitoring/reporting on vacant shifts/response times to consumers requests for assistance; communication with consumers/representatives to ascertain specific information/obtain positive outcomes; provision of staff education/training; regular review to ensure ongoing satisfaction; analysis of registered nurse tasks; review on call registered nurse process to determine effectiveness and appointment of Governance, Quality and Risk Coordinator to support daily oversight of all clinical incidents/support clinical service provision.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrated systems/processes to ensure appropriate staff in meeting consumer’s needs, the assessment bought forward feedback from two consumers relating to dissatisfaction relating to timely response from staff when requesting assistance and noted via documentation review deficits in recording appropriate care provision [considered in requirement 3(3)(a)].

The approved provider, in their response, advised of consultation with named consumers to ascertain satisfaction, and ongoing monitoring processes to ensure timely responsiveness to requests for assistance. In consideration of compliance, I am swayed by the volume of consumer satisfaction received and immediate consultation with named consumers to ascertain positive outcomes/satisfaction. I find requirement 7(3)(a) is compliant.

Requirement 7(3)(b)

Previously the service did not demonstrate effective systems to ensure staff interactions are kind, caring and respectful of each consumer’s identity, culture, and diversity and in line with organisational expectations/values. In response, improvements include: development of a workforce strategy (targeted campaigns) to attract/retain staff, partnership with industry associations to facilitate registered nurse enrolment in training programs; monitoring/reporting on vacant shifts/response times to consumers requests for assistance; communication with consumers/representatives to ascertain specific information/obtain positive outcomes; provision of staff education/training; regular review to ensure ongoing satisfaction; analysis of registered nurse tasks; review on call registered nurse process to determine effectiveness and appointment of Governance, Quality and Risk Coordinator to support daily oversight of all clinical incidents/support clinical service provision.

During this assessment contact information was gathered through interviews, observations, and document review. Effective systems ensure workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity. The organisation’s mission, vision and values promote embedding person-centred care/principles of best practice through staff induction/orientation, ongoing education, and role modelling. Most sampled consumers/representatives consider staff to be kind, caring and respectful and the assessment team observed staff interactions with consumers to reflect these aspects. I find requirement 7(3)(b) is compliant.

Requirement 7(3)(c)

Previously the service did not demonstrate effective systems to ensure staff have appropriate skills/knowledge to effectively perform their roles particularly in relation to providing care to consumers living with dementia. In addition to actions detailed in other Standard 7 requirements, improvements include: provision of staff education/competency assessment by external dementia support organisation; appointment of 2 Dementia Champions and regular monitoring of incidents relating to unmet behaviours to ensure effective strategies implemented.

During this assessment contact information was gathered through interviews, observations, and document review. Most consumers/representatives’ express satisfaction staff are competent, and the assessment team observed staff delivering in a competent manner. Document review detail processes to ensure staff knowledge/competency/ education records and staff have appropriate qualifications/ knowledge to effectively perform their roles. Interviewed staff advise the organisation to be responsive to training needs and they feel supported in delivering safe quality consumer care. I find requirement 7(3)(c) is compliant.

# Standard 8

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| Organisational governance | |  |
| 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 Quality Standard was not fully assessed. Three of five requirements were assessed and found compliant.

A decision was made on 6 July 2022 the service was non-compliant in requirements 8(3)(c), 8(3)(d), and 8(3)(e) following a Site Audit conducted on 10-17 May 2022.

Requirement 8(3)(c)

Previously the service did not demonstrate effective organisation wide governance systems, particularly in relation to continuous improvements, Serious Incident Response Scheme (SIRS) and sufficient staff numbers to provide appropriate clinical/personal care. In response, improvements include introduction of reporting dashboard to provide monthly monitoring; target registered nurse recruitment campaign; development of a bespoke virtual clinical hub; offering of nursing scholarships.

During this assessment contact information was gathered through interviews, observations, and document review. Overall, most sampled consumers/representatives consider the service to be well run noting pandemic challenges and staffing issues. Effective organisational wide governance systems are evident, examples demonstrated include continuous improvement activities and completion of projects. The organisation has implemented new clinical care planning software systems and staff training/competency review to assist in transitioning to the new program. Strategies to address staffing issues have been implemented and a new management team commenced. Organisation monitoring processes ensure regulatory compliance, feedback/suggestions/ complaints are encouraged and responded to promptly. I find requirement 8(3)(c) is compliant.

Requirement 8(3)(d)

Previously the service did not demonstrate effective risk management systems to support managing high impact/prevalence risks associated with consumers, and evaluation/review of strategies when circumstances change, prevent abuse/neglect and an incident management system used to review, investigate, and evaluate incidents.

In response, improvements include review all consumers clinical needs, staff education needs analysis, implementation of incident reporting software, provision of staff education/training/competency assessments; appointment of clinical governance quality and risk coordinator to support oversight of clinical incidents; policy update; introduction of clinical incident performance dashboard to enable monitoring status/responses; transfer of pharmaceutical contact; implement electronic AMS/psychotropic medical system with pharmacy oversight, internal review to ensure all required incidents report via; review/update of policy/procedures SIRS review and appointment of clinical governance quality and risk coordinator to support daily oversight of all clinical incidents.

During this assessment contact information was gathered through interviews, observations, and document review. Improvements to risk management systems and practices were evident. Governance software program effectively informs governance, ensures investigation where required and subsequent assessment and care plan review occurs. Alerts ensure immediate executive and quality team member notification and board reports include quality and safety reports relating to incidents (including reportable via legislative requirements) and consumer outcomes. A clinical governance quality and risk coordinator supports onsite management regarding clinical incident oversight/management and reporting to executive team ensures accountability. I find requirement 8(3)(d) is compliant.

Requirement 8(3)(e)

Previously the service did not demonstrate effective systems to ensure staff have practical knowledge of antimicrobial stewardship, minimising restraint use and principles of open disclosure including provision of information to consumers/representatives following investigation when things go wrong.

In response, improvements include review of all restrictive practices; update of relevant policy documentation, fact sheets to guide staff practice, provision of management team/staff education/training; regular monitoring processes to ensure compliance.

During this assessment contact information was gathered through interviews, observations, and document review. Monitoring processes ensure appropriate antibiotic use/application of an antimicrobial stewardship approach and board reports ensure oversight/accountability. Documentation review demonstrates application of open disclosure when things go wrong and dealing with complaints, transparency of processes is evident. The assessment team note lack of transparency in relation to requiring a code to gain access/egress of the service. Management implemented immediate actions to address this issue. I accept practice is in breach of organisational expectations – the impact is considered in requirement 3(3)(a). I find requirement 8(3)(e) is compliant.

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