Performance

Report

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| Melaleuca Aged Care | 18 October 2022 |
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| Phillip Island Homes for the Aged Association Inc | 2 August 2022 to 4 August 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 Melaleuca Aged Care (**the service**) has been considered by Alice Redden, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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.
* the provider’s response to the Assessment Team’s report received 12 September 2022.

# 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 | **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): The approved provider ensures assessment and planning, considers and addresses risks relating to consumers’ health and well-being to inform the delivery of safe and effective care.
* Requirement 3(3)(a): Consumers receive safe and effective clinical care that is best practice, tailored to needs and optimises their health and well-being in relation to blood pressure monitoring, skin care, and restrictive practices.
* Requirement 3(3)(b): Effective management of high impact or high prevalence risks associated with the care of consumers.
* Requirement 7(3)(a): The workforce is planned to deliver safe and quality care and services through an appropriate number and mix of staff.
* Requirement 7(3)(d): The workforce is trained and equipped to deliver the outcomes required by these standards.
* Requirement 8(3)(c): The approved provider ensures effective organisation wide governance of information management, continuous improvement, regulatory compliance, workforce governance.
* Requirement 8(3)(d): The approved provider ensures effective risk management of high impact or high prevalence risks associated with the of consumers, and incident management and prevention.
* Requirement 8(3)(e): Effective clinical governance framework relating to restrictive practices.
* The approved provider implements all planned actions to address identified deficiencies and establishes monitoring process to ensure ongoing compliance with the Aged Care Quality Standards.

# 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 reflected the service supported them to make informed choices to live the life of their choosing, and were treated with dignity and respect, as confirmed by care planning documentation and staff feedback.

Consumers said their culture, values, and diversity was supported by the service. Care planning documentation confirmed consumers’ religious, spiritual, and cultural needs were considered to guide staff in the delivery of culturally safe care and services.

Consumers and representatives said, and care planning documentation confirmed consumers were supported to make decisions about their care, how it should be delivered, and who should be involved in their care. Staff demonstrated knowledge of consumers’ preferences and choices, and described ways they supported consumers to communicate their decisions, and maintain relationships of choice. Consumers reflected they were supported to take risks to live their best life.

Consumers said, and care planning documentation confirmed information was provided to help consumers make informed decisions about their care and services. Staff advised information was provided through various ways to support different communication needs such as: noticeboards, meetings, menus, brochures, consumer handbook, and posters. Staff explained they supported consumers with communication barriers by tailoring information based on individual needs.

Consumers said and observations confirmed, consumers personal privacy was respected by staff, for example, staff knocked on consumers’ doors before entering. The service’s policies and procedures guided staff on the privacy and protection of consumers’ personal information.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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 found this Quality Standard non-compliant, the non-compliance is in relation to Requirement 2(3)(a) and I have provided reasons below.

The Assessment Team identified

Several care plans and assessments had missing information about consumer care interventions including risks, to inform the delivery of safe and effective care and services.

In summary, the identified gaps related to: the use of bed poles to support mobility and transfers, air mattress for pressure injuries, dignity of risk assessment for unsupervised walks, indwelling catheter care and infection history, and chemical restraint as discussed further under Requirement 3(3)(a).

In response to the findings associated with the bed poles, the service provided copies of sleep care plans, mobility transfer and dexterity care plans, daily handover sheet, and applicable policies to guide staff practice. In isolation, I have considered the bed pole example not indicative of non-compliance.

The service acknowledged the gap in care planning documentation for the air mattress, dignity of risk assessment for a named consumer’s unsupervised walks, and restrictive practice. The service provided evidence of policy revisions noted under the continuous improvement plan and documentation applicable to consumer examples.

However, in regards to the unsupervised walks and restrictive practice examples, there was limited information to demonstrate risk management strategies were appropriately considered against the consumers’ unique health and well-being needs.

The service explained and documentation confirmed an indwelling catheter plan and infection history for a named consumer had been updated, however, due to clerical error was not approved before the site audit.

I have considered the service’s written response, and have determined the weight of evidence outweighs the steps and actions taken by the service. With consideration to the identified gaps in assessment in planning across different care needs, I have determined Requirement 2(3)(a) non-compliant.

I have considered the service’s written response, and based on the totality of evidence I have determined Requirement 2(3)(d) and Requirement 2(3)(e) compliant.

Overall, consumers and representatives reflected the outcomes of assessment and planning were effectively communicated to them, despite not all consumers and representatives having a copy of the care plan. Given there was no evidence to demonstrate adverse impact, and the service has since put measures in place to provide a copy of the care plan, I have considered this example as not indicative of non-compliance.

It is acknowledged care plans for three named consumers demonstrated gaps in the documentation of personal or clinical changes. Based on contextual information provided by the service, actions taken, and low associated risk, I have determined this example as not indicative of non-compliance, for Requirement 2(3)(e). However, I have noted the evidence as most applicable, and in support of the finding for non-compliance under Requirement 2(3)(a).

I have deemed the two other requirements of Standard 2 compliant based on the weight of evidence. Consumers said, and care planning documentation confirmed consumers’ current needs, goals, and preferences, including advance care and end of life planning were identified and addressed. Overall, consumers reflected they were involved in the ongoing assessment and planning of their care and services. Consumers were supported by a multidisciplinary team of medical professionals and other providers of care and services to best support their needs, as confirmed by care plans, consumer, and staff feedback.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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 based on the balance of evidence, the following requirements are non-compliant:

Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, and tailored to their needs, and optimises their health and well-being.

Effective management of high impact or high prevalence risks associated with the care of each consumer.

I have considered the evidence provided in the service’s written response, and actions taken following the site audit. However, I have determined the gaps under Requirement 3(3)(a) and Requirement 3(3)(b) outweigh the service’s response, due to required ongoing areas of improvement across several clinical domains, such as blood pressure monitoring, skin care, pain management, and falls management.

Deficiencies were identified for the following clinical areas:

Blood glucose management

A named consumer’s care planning documentation did not consistently record their blood glucose levels ranges, or detail strategies to inform staff practice. However, it was noted two other consumers had blood glucose level information documented on their care plans. In response, the service clarified blood glucose information was recorded in clinical range monitoring documentation available for staff access. In addition, the service provided a copy of the named consumer’s diabetes management plan in place during the site audit. Given the service demonstrated appropriate clinical care was in place for the two other consumers, and provided evidence of blood glucose care monitoring for the named consumer, in isolation, I have deemed this example not indicative of non-compliance. However, note deficiencies in the operational procedure for diabetes management and insulin administration, as applicable under Standard 8.

Blood pressure monitoring

Two named consumers’ care plans demonstrated blood pressure monitoring directives were not consistently followed. For one named consumer, their blood pressure was not charted on eight occasions, and for the second named consumer was not charted on 16 occasions. No specific information was provided as to why blood pressure monitoring was not undertaken or recoded for the named consumers. I have considered this example indicative of non-compliance with consideration to potential risk, safety, and the effectiveness of best practice care.

Skin and wound care

Care and nursing staff were responsible for wound dressings, however, there was no evidence to demonstrate whether care staff had the appropriate knowledge to complete wound dressings. Wound charting documentation did not demonstrate whether wound care was reviewed and completed by a registered nurse. Skin and would care policies did not reflect best practice guidelines, and policies included minimal information to guide staff practice. In response, the service clarified it had added review of wound care policies, procedures, and education to the continuous improvement plan, however, did not provide specific information to staff undertaking wound care dressings. I have considered the example indicative of non-compliance with respect to best practice clinical care, noting the relevancy of gaps in staff training, policies and procedures under Standard 7 and 8.

Pain management

Care planning documentation for three named consumers identified gaps in pain management. For one named consumer, there was no evidence of pain charting to monitor the effectiveness of analgesia. The two other named consumers did not have any pain charting since 2018 and 2019 respectively. However, the two consumers did have current progress notes during the site audit, which did not identify the consumers experiencing pain. Based on the balance of evidence, noting low risk and low identified impact to consumer, I have considered this example not indicative of non-compliance. However, I note the relevancy of gaps in the service’s pain management policy under Standard 8.

Restrictive practice

The service was unable to demonstrate best practice, tailored clinical care for restrictive practices. There was limited evidence to substantiate whether consumers, were or were not subject to chemical restraint, and if so, how this would be tracked and monitored. In addition, a locked gate was observed at the end of the footpath to the front door of the service. The service was unable to demonstrate how it would assess consumers to ascertain if they are able to freely leave the service.

Restrictive practice policies and procedures did not align with current legislative requirements, and staff were not able to demonstrate a consistent understanding of restrictive practice, or measures in place to use it as a last resort. No medication advisory meetings were undertaken to discuss chemical restraint and psychotropic usage. In response, the service acknowledged the findings and advised restrictive practice policies, procedures, meetings and staff education had been added to the continuous improvement plan.

I have also considered an example provided of a named consumer:

The service had not identified the consumer as subject to chemical restraint. The consumer was administered a psychotropic for behavioural regulation, without a valid diagnosis to exclude the psychotropic as being classified as a chemical restraint. The effectiveness of non-pharmacological strategies were not reviewed against the consumer’s unique needs, and chemical restraint was not administered as a last resort in accordance with legislative requirements.

Given the totality of evidence, with respect to best practice, tailored clinical care that optimises health and well-being, and potential risk I have considered this example indicative of non-compliance.

Falls management

Care planning documentation for 2 named consumers indicated falls management was not appropriately managed and prevented. In addition, staff were unable to demonstrate how best practice clinical care would be provided to consumers to effectively manage high impact risk. There was minimal evidence to confirm whether clinical indicators were analysed and trended to manage and prevent high prevalence and high impact risk, or how this would inform policies and procedures. In response, the service advised policies and procedures relating to risk, in addition to falls management, was under review, and clinical indicators would be analysed going forward. Given there are ongoing areas of improvement, and associated risk, I have deemed this example indicative of non-compliance.

I have considered the service’s written response, and based on the totality of evidence I have determined Requirement 3(3)(g) compliant. I acknowledge there were gaps identified in relation to staff knowledge of antimicrobial stewardship, however, note this finding as relevant to standard 7 and 8. A named consumer did not have their history of infections recorded on their care plan or strategies to reduce reoccurrence, however, I have considered this applicable under Requirement 2(3)(a). Given the limited risk to consumers, overall, the balance of evidence demonstrated compliance with the minimisation of infection related risks. In support of this finding, the service provided a copy of the outbreak management plan, operational plans and procedures for transmission precautions, and guidelines for respiratory outbreaks.

In addition to Requirement 3(3)(g), I have deemed the 4 other requirements of Standard 3 compliant based on the weight of evidence.

Care planning documentation confirmed consumers nearing end of life were supported in a dignified and comfortable manner, with respect to their needs, goals, and preferences. Staff described processes and referrals for responding to deterioration or changes to consumers’ conditions. Overall, care plans confirmed changes to consumers’ conditions were identified and responded to in a timely and appropriate manner, noting falls management under Requirement 3(3)(b). Staff said, and documentation confirmed information about consumers’ condition, needs, and preferences was shared within the service, and other providers of care through meetings, handover notes, referrals, progress notes, and other notifications. Care planning documentation demonstrated referrals were completed in a timely and appropriate manner, for example, for speech pathology, dietetics, and geriatric care.

# 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 they received safe and effective services and supports for daily living, which was important for their health and well-being, and enabled them to do the things they wanted to do. Staff demonstrated knowledge of consumers’ goals and preferences which aligned with consumer feedback and care planning documentation.

Staff described ways consumers’ emotional, spiritual, and psychological well-being was looked after, such as spending one on one time with consumers, facilitating contact with family members, and engaging consumers with volunteer services. Consumers said, and care planning documentation confirmed consumers’ emotional and spiritual needs were met.

Consumers confirmed they were supported to participate in their community within and outside the service environment, maintain important relationships, and do things of interest to them.

Staff explained and observations confirmed, information about consumers’ needs was communicated through verbal and documented information processes, noting deficiencies as discussed under Requirement 8(3)(c). Care plans confirmed timely and appropriate referrals were completed to support consumers’ varying needs and interests.

Overall, consumers reflected meals were of a suitable quality and quantity. Consumers said they were able to choose what their meal preferences were for the day, or request alternative options if nothing was suitable. Equipment required for activities for daily living was observed to be suitable, clean and well maintained. Maintaince documentation demonstrated regular cleaning and servicing of equipment was undertaken.

# 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

Consumers and representatives said the service environment felt welcoming, safe, comfortable, and easy to understand and navigate. Observations confirmed consumers were supported to belong through personalised rooms, furniture, photographs, and artwork. The service environment was observed to have dementia enabling principles of design with wide, level pathways, and signage to support consumers’ interaction and function.

Consumers said, and observations confirmed consumers could move freely between indoors and outdoors, noting a locked gate as mentioned under Requirement 3(3)(a). Staff feedback and documentation confirmed an appropriate cleaning and maintenance system was in place to ensure the service environment was safe, clean, well maintained, and comfortable. Maintenance documentation confirmed preventative maintenance and faults were actioned in a timely manner.

Overall, consumers said and observations confirmed furniture, fittings, and equipment were safe, clean, well maintained, and suitable for consumers’ needs. Shared equipment was observed to be disinfected, with hand sanitisers readily available.

**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

I have assessed this Quality Standard as compliant as I am satisfied based on the balance of evidence and the service’s written response, all requirements under Standard 6 are compliant.

Two named consumers indicated they had not provided feedback about meal quality at the service. In response, the service provided evidence of how the two consumers were supported to provide feedback and complaints, and steps undertaken to monitor the feedback.

The service provided a copy of complaints and feedback records, and acknowledged a limited number of complaints were recorded due to staff promptly actioning feedback when received. The service explained it had sent out a reminder to staff to record feedback and complaints, and added this item to the continuous improvement plan.

Given the totality of evidence which demonstrated consumers and representatives were supported to provide feedback and complaints, and associated low risk, I have considered Requirement 6(3)(a) compliant.

In addition, the service updated complaints and feedback information material, and added feedback and complaints as a standing agenda item in the service’s newsletter. The service also provided evidence of consumer engagement in voluntary feedback and complaints processes.

Based on the totality of evidence, overall, consumers reflected they were aware of advocacy and language services. In response, the service explained it had updated informational material for language and advocacy services. Given the balance of evidence, and low impact to consumers, I have determined Requirement 6(3)(b) compliant.

It is noted the service’s complaints and feedback policy did not specify processes for responding to complaints, timeframes, and documenting outcomes and evaluation and entering information into the continuous improvement plan. However, based on the balance of evidence which demonstrated open disclosure was used in incident reports, and feedback and complaints records, I have determined Requirement 6(3)(c) compliant.

In addition, based on balance of evidence which demonstrated feedback and complaints were addressed to improve consumers individual experience of care and services, I have determined Requirement 6(3)(d) compliant. However, as applicable under Requirement 8(3)(c), there was minimal evidence to confirm feedback and complaints information was used to inform improvement opportunities across the service generally.

**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. | Non-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. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied based on the balance of evidence, the following requirements are non-compliant:

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.

The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Most consumers said the staffing level did not impact their care, however, staff expressed concerns regarding the skill mix of the workforce. Staff interviews and staff rosters confirmed there was no endorsed enrolled nurse or registered nurse after hours, with feedback reflecting concern for the delivery of safe and effective quality care in case of emergencies or incidents. Incident documentation demonstrated some delay into the review of incidents or identification of injuries for named consumers noted under Standard 3, and there was no evidence to substantiate whether falls data was analysed to find out when the majority of falls occurred, and if there was a need to adjust the number and skill mix of staff rostered.

In response, the service clarified on call registered nurses were available after hours. The service explained that it intended to advertise for enrolled nurses on all shifts, and added this to the continuous improvement plan. In regards to falls risk, and potential adjustment of staffing ratios, the service explained falls trends would be monitored going forward. Given the identified deficiencies, and ongoing improvements required, I have determined Requirement 7(3)(a) non-compliant.

Based on the balance of evidence, I have determined Requirement 7(3)(d) non-compliant due to the ongoing improvements required for workforce training and support to deliver outcomes required by these standards.

I have also considered evidence presented under Requirement 7(3)(c) applicable to the finding of non-compliance for Requirement 7(3)(d), as the evidence primarily related to deficiencies in workforce training, support, and guidance.

I have placed weight on the following deficiencies in finding Requirement 7(3)(d) non-compliant:

As identified across Standard 3, staff were unable to demonstrate consistent knowledge of restrictive practice and how to minimise the use of restraint, antimicrobial stewardship, and falls management and prevention. Staff said, and documentation confirmed there was minimal training for restrictive practices, falls, skin, wound management, and how to identify and respond to acute clinical deterioration. Mandatory staff training was reported as 61% complete during the site audit. In response, the service provided evidence of staff training, with mandatory modules such as COVID-19 and personal protective equipment. However, it is noted, a majority of modules were commenced in 2020, with no clear indication as to when they were completed or what the result was.

In addition, there were no clear guidelines for staff to record changes in consumers care needs, with inconsistent record management for paper and electronic documentation demonstrated in some of the examples across Standard 3. The service explained reminders had been sent out to staff of record management guidance, and noted policies and procedures were under review to support the workforce as noted in the continuous improvement plan.

In response to the lack of clear guidance and centralised processes to manage high prevalence risks noted under Requirement 3(3)(b), the service explained additional training, policy and procedures were under review, cited in continuous improvement plan.

The service addressed findings about the lack of infection control protection lead training, and provided context which confirmed the service’s newly nominated lead was enrolled in the appropriate course to fulfil their duties. The service explained support would be provided by the current lead in the interim. In isolation, I have not deemed the infection control protection lead example indicative of non-compliance.

In response to feedback about the competency of personal care staff administering insulin under Requirement 3(3)(a), the service clarified the applicable staff members were current registered nurse or enrolled nurse students who were trained and assessed by the registered nurse. However, the service explained insulin management was added to annual training requirements.

I have considered Requirement 7(3)(e) compliant based on the balance of evidence which demonstrated most staff appraisals were completed within the service’s annual timeframe. In the service’s written response, it was acknowledged one on one staff performance and training was provided, however, not clearly documented and would be actioned under the continuous improvement plan.

I have deemed the 1 other requirement of Standard 7 compliant based on the weight of evidence. Consumers said, and observations confirmed consumers were treated in a kind and caring manner with respect to their identity, culture, and diversity.

**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. | 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 based on the balance of evidence, the following requirements are non-compliant:

* Effective organisation wide governance systems relating to: information management, continuous improvement, regulatory compliance.
* Effective risk management systems and practices including managing high impact or high prevalence risks associated with the care of consumers.
* Where clinical care is provided—a clinical governance framework, including but not limited to the following: minimising the use of restraint.

I have considered the service’s response, however, due to the gaps identified in the service’s governance systems and associated impact, I have determined Requirement 8(3)(c) non-compliant. As identified across standards 3, 6 and 7 there lacked clear consistent guidance on how staff should record hard copy and electronic records management information, resulting in missing or incorrect consumer information. Some policies and procedures were overdue for review, did not align with best practice to guide staff in the delivery of safe and effective care, such as restrictive practices. Although the service demonstrated it addressed consumer’s complaints, consumer, staff, and documentation were unable to confirm what improvements have been made to the delivery of care and services based on feedback and complaints information. Under Requirement 3(3)(a) there were deficiencies noted in the identification and management of restrictive practice, which did not align with best practice and legislative requirements. In the service’s response, it was advised the entire documentation system, associated policies, and staff training were under review as noted on the continuous improvement plan.

I have determined Requirement 8(3)(d) non-compliant based on the balance of evidence, and associated impact. As discussed under Requirement 3(3)(b) the service was unable to demonstrate how it effectively managed high impact, or high prevalence risks associated with the care of consumers. In response, the service advised there were policies in place, however, acknowledged inconsistency in the management of high impact risk, with processes and policies undergoing review under the continuous improvement plan.

I have considered the service’s response and have determined Requirement 8(3)(e) non-compliant due to gaps identified with restrictive practices and the minimisation of restraint as noted under Requirement 3(3)(a). I have also noted deficiencies in the clinical trends analysis of infection information and infection prevention control policies, and consider this as an area of improvement. In response, the service advised it is conducting a review of the associated policies and processes as noted under the continuous improvement plan.

Based on the balance of evidence, and the service’s response, I have determined Requirement 8(3)(a) and Requirement 8(3)(b) compliant. Overall, consumer feedback and documentation confirmed consumers were engaged in the planning and evaluation of care and services. Overall, based on the totality of evidence, the governing body demonstrated accountability for the delivery of safe quality care and services through monthly meetings and clinical reporting.

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-2)