Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Morrie Evans Wing Nursing Home |
| Service address: | Coster Street BENALLA VIC 3672 |
| Commission ID: | 3470 |
| Approved provider: | Benalla Health |
| Activity type: | Site Audit |
| Activity date: | 4 October 2022 to 7 October 2022 |
| Performance report date: | 22 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 Morrie Evans Wing Nursing Home (**the service**) has been prepared by Denise McDonald, 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.
* the provider’s response to the assessment team’s report received on 14 November 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* **Requirement 3(3)(a) –** the service ensures each consumer gets safe and effective personal care, clinical care, or both personal and clinical care, that is best practice, and is tailored to their needs, and optimises their health and well-being.
* **Requirement 4(4)(f) –** the service ensures where meals are provided, they are varied and of suitable quality and quantity.
* **Requirement 6(3)(c) –** the service ensures appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* **Requirement 6(3)(d) –** the service ensures feedback and complaints are reviewed and used to improve the quality of care and services.
* **Requirement 7(3)(a) –** the service ensures 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.
* **Requirement 7(3)(d) –** the service ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards.
* **Requirement 8(3)(c) –** the organisation ensures effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance including the assignment of clear responsibilities and accountabilities, regulatory compliance and feedback and complaints.

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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 respect and felt their individual identity, diversity and dignity was valued. Staff were observed to treat consumers respectfully and displayed an understanding of consumers’ backgrounds, identities, and cultural practices. The service displays visual representations of consumers’ cultural backgrounds and preferences in their rooms, employs an indigenous liaison officer, and provides religious and cultural supports and activities in accordance with consumers’ preferences.

Consumers and representatives advised consumers are supported to make decisions about their own care and the services delivered. Consumers confirmed they are supported to make connections and maintain relationships of choice, including intimate relationships.

The service demonstrated consumers are supported to take risks and to live the best life they can. Staff described how consumers are supported to understand the benefits and possible harm when the make decisions about taking risks, and how consumers are involved in problem-solving solutions where possible.

Consumers and representatives reported receiving relevant and current information which is communicated effectively to enable consumers to exercise choice. Staff described how a variety of information is provided to consumers each day.

Staff described the practical ways they respect the privacy of consumers, such as knocking on consumers’ doors prior to entering, maintaining consumer privacy when providing personal cares and protecting consumer information through password protected electronic case management systems. Consumers confirmed they feel their privacy is respected.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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 representatives confirmed their involvement and consultation in care planning and assessment processes. Review of care planning documentation demonstrated risks to consumers’ health and well-being are identified and documented as part of the care planning process.

Consumer care planning documentation demonstrated assessment and planning identified and addressed consumers’ individual needs, preferences and goals or strategies, including advance care planning. Consumers and representatives said they feel the service meets consumers’ current care needs.

Consumers and representatives confirmed the service supports them to involve other people of their choice in the assessment, planning and review of their care and services and that the outcomes are communicated with them. This was evidenced in care planning documentation. Consumers and representatives said a copy of the care plan is provided to them.

Consumers and representatives said consumers’ cares and services are reviewed monthly, or when circumstances change which impact on the needs or preferences of the consumer. The review of care planning documentation demonstrated that cares and services are reviewed regularly and in line with the organisation’s policies and procedures.

# Standard 3

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

Findings

The Assessment Team found that the following requirements were not met:

* Each consumer gets safe and effective personal care, clinical care, or both personal 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.

In consideration of Requirement 3(3)(a), the Assessment Team found deficiencies in restrictive practices documentation, specifically surrounding documentation of consent and consultation, behaviour support plans and the psychotropic register. The Assessment Team reported deficiencies in the charting of wound care for two named consumers. Review of consumer care documentation demonstrated appropriate pain charting was not being completed. While, deficiencies in documentation were identified there was no evidence which supported wounds were deteriorating or consumers were experiencing uncontrolled pain.

The Approved Provider’s written response received on 14 November 2022 acknowledged the deficiencies and advised of action taken to remedy the deficiencies brought forward by the Assessment Team. In relation to restrictive practices, the service has implemented new risk assessment, informed consent, authorisation, review and evaluation documentation and have commenced the development of behaviour support plans. The psychotropic register has been updated and the service is reviewing all consumers subject to restrictive practices. The service has made improvements to wound management including the appointment of two registered nurses who will be responsible for wound management and the commencement of electronic wound charting and improved communication relating to wound care. The service has commenced reviewing their processes around pain assessment and charting and has planned external training for staff in relation to pain management.

Whilst I acknowledge the actions taken by the Approved Provider, at the time of the Site Audit, the service did not demonstrate consumers were receiving safe and effective personal and clinical care with regards to restrictive practices, behaviour and wound and pain management.

Therefore, I find Requirement 3(3)(a) is non-compliant.

In consideration of Requirement 3(3)(b), the Assessment Team found the service did not effectively manage high impact or high prevalence risks associated with the care of each consumer. Care planning documentation contained significant gaps in documentation relating to pain, wound and weight charting. The Assessment Team reported care documentation of a named consumer, who was assessed as being malnourished and was subsequently placed on a high energy high protein diet, demonstrated weight charting had not occurred. Review of care documentation for two named consumers showed inadequate wound charting was being completed. The Assessment Team identified further gaps in the documentation of monitoring, management, and review for a consumer with chronic pain.

I have considered the evidence in relation to pain and wound charting under Requirement 3(3)(a) where it supports clinical care has not been delivered tailored to the needs of consumers.

The Approved Provider’s written response, received on 14 November 2022 provides further information in relation to the named consumer who was identified as being malnourished which supports the consumers weight was being regularly monitored and they had been reviewed by allied health professionals regarding their nutritional support needs. While I note the evidence had been bought forward to support the consumer had not been weighed on certain dates, I am unable to establish that weight monitoring has not occurred in accordance with the consumers weight monitoring schedule. I acknowledge evidence submitted substantiates the consumer has gained weight and as having an increased appetite over recent months. I also note alternative supplementation has been recommended based on the consumer reporting fatigue with the current supplement which indicates the supplement is provided frequently. I consider this supports compliance with this requirement.

Therefore, I find Requirement 3(3)(b) is compliant.

I am satisfied the remaining five requirements of Standard 3 are compliant.

Staff described the way care delivery is personalised for consumers nearing the end of life and the processes used by staff in end-of-life care delivery. Care planning documentation evidenced end of life care plans which document consumers’ goals and preferences.

Progress notes reflected timely identification and response to changes in a consumer’s condition and staff explained the assessment and communication process following a change of condition. Consumers and representatives expressed satisfaction with the communication of consumers’ needs and preferences within the service.

The service demonstrated a process for timely and appropriate referrals to individuals, other organisations and providers of other care and services, including allied health professionals.

The service had documented policies and procedures to support the minimisation of infection related risks and antimicrobial stewardship, and a process in place for the management of COVID-19 antiviral treatment. Consumers and representatives indicated that staff follow safe infection control processes.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Assessment Team found that the following requirement was not met:

* Where meals are provided, they are varied and are of suitable quality and quantity.

Consumers raised concerns about the quality of the meals provided and the temperature at which they are served. Consumers said that the service has failed to act on feedback provided by consumers regarding meals. Management described planned improvement actions but attributed concerns about food temperature to inadequate allocation of staff.

The Approved Provider’s written response received on 14 November 2022 acknowledged the deficiencies identified during the Site Audit and confirmed actions taken following the Assessment Team’s feedback including daily audits of the temperature of the meals and preparing toast, teas and coffees fresh on site. Additionally, a Bain Marie has been purchased to ensure meals are kept warm and a new consumer focus group has been established, specifically to discuss food related concerns and provide feedback to the service.

Whilst I acknowledge the actions taken by the Approved Provider, at the time of the Site Audit the service failed to demonstrate that meals provided are of suitable quality.

Therefore, I find Requirement 4(3)(f) is non-compliant.

I am satisfied the remaining six requirements of Standard 4 are compliant.

Consumers and representatives confirmed consumers feel supported to do the things they want to do, and staff demonstrated knowledge of what is important to consumers and their preferences for activities of daily living. The Assessment Team observed consumers engaging in a range of activities and services of interest to them.

Consumers described how the service supports their emotional, spiritual, and psychological well-being. Care planning documentation demonstrated emotional and psychological assessments had been completed and staff were observed to be supporting consumers in a way that promoted their individual well-being.

Consumers said they are supported to maintain relationships and continue to do things of interest to them. Care documentation recorded how consumers wish to participate in activities within and outside the service and maintain relationships.

Consumers and representatives indicated that information about consumers’ needs and preferences was appropriately communicated. Staff described the various ways information about consumers’ condition, needs and preferences are communicated including through care planning documentation, progress notes and verbal handover.

Care planning documentation demonstrated that appropriate referrals are made to other services and organisations to support and enhance consumer well-being.

The Assessment Team observed equipment was safe, clean, and well-maintained. Staff described their roles in assessing safety and suitability of the equipment and ensuring it is safe and well-maintained. Maintenance records confirmed equipment is routinely maintained and reactive maintenance is attended to promptly.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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 Assessment Team observed the service environment to be clean, bright, welcoming, and easy to navigate with design features throughout the service which supported consumer mobility and encouraged independence. Consumers considered the service a nice place to live and described how the service environment impacts their day-to-day living in a positive way.

Consumers expressed satisfaction with the cleaning and maintenance of the service and said they feel safe and free to move around the service, both indoors and outdoors. Staff described how they support consumers to access areas of the service, including the outside courtyards when they wish.

Consumers and representatives said they furniture, fittings and equipment are safe and kept clean and that they feel safe and comfortable when staff use the equipment to deliver care.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The Assessment Team found that the following requirements were not met:

* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Feedback and complaints are reviewed and used to improve the quality of care and services.

In consideration of Requirement 6(3)(c), consumers and representatives said that they do not feel that the service responds to complaints appropriately or provides appropriate communication following a complaint. Consumer meeting minutes for the three months prior to the Site Audit demonstrated ongoing complaints, however, the Assessment Team identified that no complaints had been recorded in the service’s feedback register and consumers reported that appropriate action had not been taken.

The Approved Providers written response, received on 14 November 2022 acknowledges the deficits identified and details improvements made by the service since the Site Audit. These improvements include the recording and managing of complaints through an electronic incident management system, the implementation of a new process whereby complaints are investigated by the nurse unit manager and tabled at clinical governance meetings, the addition of feedback boxes in accessible locations, and enhanced communication processes.

Whilst I acknowledge the Approved Provider’s actions detailed in their written response dated 14 November 2022, at the time of the Site Audit, the service failed to demonstrate appropriate action was taken in response to complaints and an open disclosure process used when things go wrong.

Therefore, I find Requirement 6(3)(c) non-compliant.

In consideration of Requirement 6(3)(d), consumers said they do not feel that feedback and complaints are reviewed and used to improve the quality of care and services provided. Management and staff were unable to describe how service improvements have been made as a response to feedback from consumers. Although the service’s complaints management policy stated that complaint data should be analysed and used for continuous improvement, the feedback register or PCI did not detail changes made in response to feedback and complaints.

The Approved Provider’s response received on 14 November 2022 acknowledged the deficiencies and reports the service has strengthened their processes to gather more data to feedback into the service’s continuous improvement system. The Approved Provider has provided evidence of the completion and analysis of a survey conducted following the Site Audit. The service anticipates further opportunities to trend data and feedback with the additional avenues available to consumers, representatives and staff to provide feedback and make complaints.

Whilst I acknowledge the Approved Provider’s actions since the Site Audit, the service failed to demonstrate that feedback and complaints were reviewed and used to improve the quality of care and services provided. Therefore, I find Requirement 6(3)(d) non-complaint.

I am satisfied that the remaining two requirements of Standard 6 are compliant.

Consumers and representatives described how they can provide feedback to the service, including at monthly consumer meetings and felt encouraged and supported to do so. Staff demonstrated an understanding of the feedback and complaints process and described how they support consumers to provide feedback.

The Assessment Team observed information relating to advocacy services, language services and external complaints mechanisms was available within the service.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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

The Assessment Team found that the following requirements were not met:

* 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 the Quality Standards.

In consideration of Requirement 7(3)(a), the Assessment Team found deficiencies in the number and mix of members of the workforce which impacted on the delivery of safe and quality care and services. Consumers, representatives, and staff expressed that they did not believe there were adequate numbers of staff at the service, while consumer expressed there were some delays in responding to call bells, there was no evidence to support these delays had adversely impacted the consumer. Staff detailed impacts on care and services, including delays in responding to call bells, the inability to engage with and attend to personal cares of consumers, and insufficient time to complete training. Management considered the staffing situation to be a high risk to consumers and described retention and recruitment challenges and strategies for addressing the staff shortage. Management advised that call bell data is not able to be monitored and is in consultation with the supplier to provide this functionality. Rostering documentation supported shifts were unfilled.

The Approved Provider’s written response, received on 14 November 2022 refutes there was sufficient evidence to support a finding of non-compliance and described the challenges the service is experiencing in recruiting and retaining staff, as reflective of industry-wide shortage of nurses and the service’s regional location. The Approved Provider’s response states they believe the service has maintained safe and quality care and services to consumers, however deficiencies have been identified in the delivery of care to meet consumers needs. I acknowledge the organisation has plans to recruit additional staff and obtain the capability to review call bell data, with the intent of introducing monthly call bell data audits thereafter.

Whilst I acknowledge the circumstances of the Approved Provider and the difficulty in obtaining staff, on the totality of the evidence contained in the Assessment Team report and the Approved Provider’s written response dated 14 November 2022, the number and mix of members of the workforce does not enable the provision of safe and quality care and services.

Therefore, I find Requirement 7(3)(a) as non-compliant.

In consideration of Requirement 7(3)(d), a review of staff files and training documentation found the workforce is not satisfactorily trained, equipped and supported to deliver the outcomes required by the Quality Standards. Staff confirmed that they had not received training on restrictive practices, antimicrobial stewardship, the prevention of elder abuse or open disclosure, and reported not having sufficient time to complete training. No evidence of staff training in the Quality Standards was provided to the Assessment Team. Management advised that there is currently no training being provided due to the current workforce shortage.

The Approved Provider’s written response, received on 14 November 2022 acknowledges that the service has an opportunity to improve the education and training provided to staff. The Approved Provider described actions taken since the Site Audit including obtaining access to a number of training modules including the Quality Standards, restrictive practices, the serious incident response scheme and antimicrobial stewardship. The Approved Provider has also allocated specific times within the roster for staff to undertake training and have arranged for specialised face-to-face training.

Whilst I acknowledge the proposed actions of the Approved Provider in the response dated 14 November 2022, I consider they have failed to demonstrate that the workforce is trained, equipped and supported to deliver the outcomes required by the Quality Standards at the time of the Site Audit.

Therefore, I find Requirement 7(3)(d) non-compliant.

I am satisfied the remaining three requirements of Standard 7 are complaint.

Consumers and representatives said that staff interact with consumers in a kind, caring, and respectful way. The Assessment Team observed management and staff addressing consumers by their name and using respectful language and ensuring they were at consumer’s face height when assisting consumers.

Consumers and representatives felt staff were competent in their roles and management described how they determine staff competence and capability. Workforce records demonstrated that staff have the appropriate qualifications, knowledge and experience to perform their duties.

The service demonstrated a process for regular assessment, monitoring, and review of staff performance, including annual performance appraisals.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | 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 Assessment Team found that the following requirement was not met:

* 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.

The Assessment Team found that, although the service demonstrated a process for continuous improvement the service was not capturing, recording, or using complaints as part of the continuous improvement process. Feedback and complaints were found to not be appropriately recorded and investigated and the outcomes have not been communicated to consumers and representatives.

The Assessment Team found deficiencies in the organisation’s regulatory compliance around changes to restrictive practice legislation. Changes in restrictive practice legislation had been discussed at an organisational level and implemented into the organisation’s policy, however, the consumer care documentation and staff training records demonstrated that these changes had not been implemented at the service level. The care planning documentation demonstrated that several Consumers subject to restrictive practices were found to not have the required behaviour support plans and/or completed consents.

The Approved Provider’s written response, received on 14 November 2022 acknowledges the organisation has an opportunity to improve information management processes in organisational governance, particularly in relation to regulatory compliance for restrictive practices and the use of consumer feedback to inform their quality improvement processes. The strategic plan provided by the Approved Provider demonstrates the organisation’s commitment to governance structures. The organisation has identified that the service’s electronic care planning system does not meet legislative requirements in regard to restrictive practices and the organisation has commenced implementation of a suite of additional forms and behaviour support plans. The organisation has commenced using an electronic case management system to record feedback and complaints and enhanced processes around the investigation, analysis and communication following the receipt of feedback or complaints.

Whilst I acknowledge the actions of the Approved Provider in their response dated 14 November 2022, I consider they have failed to demonstrate effective governance systems relating to regulatory compliance, continuous improvement and feedback and complaints. Therefore, I find Requirement 8(3)(c) non-compliant.

I am satisfied the remaining four requirements of Standard 8 are compliant.

Consumers expressed that the service was well run, however were not able to describe how they have a say in service delivery and improvement. The service holds monthly consumer meetings which is chaired by a consumer and the review of the consumer meeting minutes demonstrate that consumers participate in these meetings and their input is recorded.

The organisation has appropriate mechanisms for oversight by the governing body, including a governance framework consisting of polices and procedures, internal audits, and benchmarking and monitoring of key data. Reviews of internal audit results demonstrated how the governing body supports the service to deliver care and services that aim meet the Quality Standards.

The organisation has an integrated risk management framework that ensures clinical risks are identified, minimised, and managed and includes an elder abuse prevention, response and compulsory reportable assault policy, and an incident management framework. The service presented a suite of policies, procedures, and guiding documents in relation to the provision of clinical governance, including antimicrobial stewardship, infection control, minimising the use of restraint and open disclosure.

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