Performance

Report

**1800 951 822**

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| Name of service: | Murravale Aged Care Facility |
| Service address: | 6-10 Haydon Street MURRURUNDI NSW 2338 |
| Commission ID: | 0330 |
| Approved provider: | Murravale Retirement Home Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 November 2022 to 23 November 2022 |
| Performance report date: | 3 January 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 Murravale Aged Care Facility (**the service**) has been prepared by M. Nassif, 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 14 December 2022.
* The performance report dated 23 June 2022 following a Site Audit undertaken from 26 April to 29 April 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 | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **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 | **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)(e) – the provider ensures care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of consumers.
* Requirement 3(3)(a) – the provider ensures each consumer gets safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being.
* Requirement 3(3)(b) – the provider ensures effective management of high-impact or high-prevalence risks associated with the care of each consumer.
* Requirement 3(3)(c) – the provider ensures the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.
* Requirement 3(3)(d) – the provider ensures 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.
* Requirement 3(3)(e) – the provider ensures 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.
* Requirement 8(3)(d) – the provider ensures effective risk management systems and practices, particularly in relation to managing high impact or high prevalence risks associated with care of consumers and managing and preventing incidents.

# 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)(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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 2(3)(e) is non-compliant.

The Service was found non-compliant in Standard 2 in relation to Requirements 2(3)(a), 2(3)(b) and 2(3)(e) following a site audit in April 2022. Evidence in the Assessment Contact – Site audit report dated 22 to 23 November 2022 supports that the Service has implemented improvements to address the non-compliance and is now compliant with Requirements 2(3)(a) and 2(3)(b). However, improvements have not been effective and I find the Service non-compliant with Requirement 2(3)(e) and have provided evidence and reasoning below.

**Requirement 2(3)(a)**

The Assessment Contact – Site report identified deficiencies in relation to assessment and planning not adequality considering all risks in relation to consumers’ health and well-being. The report brought forward the following examples to highlight the deficiencies:

* One consumer had limited information in their care plan to guide staff in relation to their eating disorder. Their care plan stated they are at risk of pressure injury and staff said the consumer has an air mattress but this was not recorded in the consumer’s care plan. The care plan also does not include recommendations from a wound specialist. I have considered this under Requirement 3(3)(e) as it relates to documentation of consumer’s condition, needs and preferences.
* One consumer’s mobility assessment did not consider recommendations by a physiotherapist. The consumer was also assessed by an external organisation in relation to their behaviour and recommendations were made however these were not reflected in the consumer’s care plan. I have considered this under Requirement 3(3)(e) as it relates to documentation of consumer’s condition, needs and preferences.
* Risk assessments and investigations were not completed after one consumer had frequent falls to consider the cause of falls and strategies to prevent reoccurrence. I have considered this under Requirement 3(3)(b) as it relates to ineffective management of high impact and high prevalent risks.

The evidence presented under this Requirement is insufficient alone to support that assessment and planning does not include consideration of risks and does not inform the delivery of safe and effective care and services. Therefore, on the balance of the evidence before me, I find Requirement 2(3)(a) compliant.

**Requirement 2(3)(b)**

The Assessment Contact – Site report identified deficiencies in relation to initial assessments and palliative care plans not being completed for consumers identified as being palliative and plans being generic. The report brought forward the following examples to highlight the deficiencies:

* One consumer was not assessed on admission to the service within the timeframe set in the service’s assessment schedule.
* One consumer’s continence assessment was not regularly reviewed when their continence issues worsened to establish trend and assess the consumer’s current needs. This has been considered under Requirement 2(3)(e) as it relates to regular review of care and services.
* One consumer’s palliative care plan was not personalised to the consumer’s needs, goals and preferences.

The provider’s response addressed the deficiencies identified above and provided clarifying information in support of compliance:

* In relation to the consumer whose initial assessment was not completed, the response stated that the service had completed this and provided evidence.
* In relation to the consumer with a palliative care plan that was not personalised, the response provided evidence of a palliative care plan that was personalised.

I am persuaded by the provider’s response which demonstrated assessment and planning addresses consumer’s current needs, goals and preferences, including end of life planning. No further consumer examples was brought forward, therefore on the balance of the evidence before me, I find Requirement 2(3)(b) compliant.

**Requirement 2(3)(e)**

The Assessment Contact – Site report identified deficiencies in relation to care and services plans not regularly being updated and not reflecting changes in consumers’ circumstances and needs. The report brought forward the following examples to highlight the deficiencies:

* One consumer’s care plan was not updated with recommendations made by a dietician. As the consumer’s care was reviewed, but updates were not documented, this has been considered under Requirement 3(3)(e) where it is relevant.
* One consumer’s care plan contained limited information to guide staff in relation to their eating disorder. This has been considered under Requirement 3(3)(e) where it is relevant as the issue relates to documentation rather than regular review of care and services.
* Two consumers were not reviewed post incidents, such as falls and toileting incidents or when transferred back from hospital, to determine the effectiveness of care and services.
* One consumer’s continence assessment was not regularly reviewed when their continence issues worsened to establish trend and reassess the consumer’s current needs.

The provider’s response does not directly address the specific deficiencies identified above. The evidence brought forward under this Requirement identified multiple consumers whose care and services were not reviewed regularly for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumers. Therefore, on the balance of the evidence before me, I find Requirement 2(3)(e) non-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. | 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. | Non-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. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d) and 3(3)(e) are non-compliant.

The Service was found non-compliant in Standard 3 in relation to Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e) and 3(3)(f) following a site audit in April 2022. Evidence in the Assessment Contact – Site report dated 22 to 23 November 2022 supports that the Service has implemented improvements to address the non-compliance and is now compliant with Requirement 3(3)(f). However, improvements have not been effective and I find the Service non-compliant with Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), and 3(3)(e) and have provided evidence and reasoning below.

**Requirement 3(3)(a)**

The Assessment Contact – Site report identified deficiencies in relation to wound, pain, bowel, unplanned weight loss and medication management. The report brought forward several deficiencies, I consider the following relevant to this Requirement:

* Increase in consumer A’s antipsychotic medication was not being monitored for effectiveness, consent had not been obtained for the increase in medication and there was no documentation of the risks and benefits of the medication being discussed with the consumer or their representative.
* Two consumers did not have their wound consistently monitored in line with best practice and not treated in line with their treatment plan.
* Consumer B’s pain was not assessed and no interventions to manage the consumer’s pain was recorded.
* In relation to consumer C:
  + They were assessed by clinical staff as having moderate depression. There was no evidence of further follow up.
  + Constipation was identified as a possible cause for the consumer’s distress however there was no evidence of individualised interventions or referral to a medical officer for further review.
  + Antibiotics was prescribed for an infection however there was no indication of monitoring the infection following the completion of the course of antibiotics.
  + Care planning documents identified transfer needs however these have not been followed.
* Consumer D has wandering behaviour and review by an external organisation recommended that this may be due to pain however there was no evidence that the consumer’s pain was being monitored and assessed as a causative factor for the consumer’s wandering behaviour. Recommendations were also made to increase the consumer’s toileting schedule however this was not implemented. Evidence in relation to consumer E was provided under Requirement 3(3)(d) however has been considered under this Requirement as it is more relevant.
* Two consumers’ falls was not managed in line with best practice, including undertaking neurological observations in line with the service’s guidelines and implementation of interventions to prevent further falls.

The provider’s response addressed some of the deficiencies identified above:

* The provider’s response provides evidence that consumer A’s representative provided consent to the commencement of the antipsychotic medication but not the increase of medication. The response also evidenced the representative understood the risks and benefits of commencing the medication, but again not in relation to the increase in medication.
* In relation to consistency in monitoring wound, the provider’s response stated the information in the Assessment Contact – Site report was incorrect but did not provide evidence to support consistent monitoring of the wound in line with best practice. The response did not adequately address treatment of wound in line with the consumers’ wound plan, with evidence provided in the report demonstrating gaps in treatment of the wound.
* The provider’s response does not directly address deficiencies in relation to consumer B’s pain management and it is not clear from the information provided in the response that the service has adequately addressed this deficiency.
* In relation to consumer C, the provider’s response:
  + Acknowledged there was no follow up after the depression assessment completed.
  + Stated a report had been completed indicating the symptoms of infection had cleared, however no evidence of the report was included in the provider’s response.
  + Stated the consumer’s transfer needs has been reviewed by a physiotherapist since the Assessment Contact was conducted and have identified clear strategies. Further evidence of this was not provided, including implementation of strategies.
* The response acknowledged the deficits in relation to consumer D.
* In relation to falls management, for both identified consumers the response stated neurological observations were undertaken, however this was not clear from the evidence provided in the response.

While I acknowledge the service has taken appropriate actions to address some of the deficiencies, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The provider’s response also does not adequality address all deficiencies. The evidence brought forward under this Requirement identified multiple consumers who were not receiving clinical care that is best practice, for example in relation to restrictive practice and wound management. The evidence brought forward under this Requirement also demonstrated clinical care is not tailored to consumer’s needs or optimises their health and well-being, for example in relation to wound, pain and behaviour management. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(a) non-compliant.

**Requirement 3(3)(b)**

The Assessment Contact – Site report identified deficiencies in relation to the management of high impact and high prevalence risks, including in relation to weight, falls, diabetic and incident management. The report brought forward the following examples to highlight the deficiencies:

* One consumer, with diabetes, did not have their sugar levels monitored in accordance with their diabetic plan. Staff said the consumer’s normal sugar level range was based on hospital standards and there was no directive from a medical officer on the normal sugar level range for the consumer.
* Incidents were not investigated, or preventative measures implemented, in relation to one consumer involved in several medication incidents.
* One consumer with an eating disorder did not have their food consumption consistently monitored to monitor and manage the consumer’s weight.
* For one consumer, falls were frequent and investigations did not occur to determine cause of falls and strategies to minimise reoccurrence.

The provider’s response addressed some of the deficiencies identified above:

* In relation to the consumer with diabetes, the response included evidence that the consumer’s sugar levels was monitored in accordance with their diabetic plan. The response also stated a diabetic directive was included in the consumers care planning documents. However, evidence provided in the response does not clearly outline if the directives are from a medical officer.
* In relation to the consumer involved in medication incidents, the response acknowledged incident management could include more information and details are minimal.
* In relation to the consumer with an eating disorder, the response evidenced the consumer’s food consumption was consistently monitored for the month of October 2022.
* In relation to the consumer who frequently falls, the response does not address interventions implemented to manage the consumer’s falls. The response also does not address whether the consumer who frequently fell had investigations undertaken to determine causes and strategies to minimise reoccurrence.

While I acknowledge the service has adequately addressed some of the deficiencies, the provider’s response does not address all deficiencies. The evidence brought forward under this Requirement identified multiple consumers whose high impact or high prevalent risks, such as falls, diabetes and medication incidents, were not effectively managed. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(b) non-compliant.

**Requirement 3(3)(c)**

The Assessment Contact – Site report identified deficiencies in relation maximising comfort, pain management and not following consumer’s end of life wishes. The report brought forward the following examples to highlight the deficiencies:

* One consumer was provided oxygen to assist with their shortness of breath however oxygen levels was increased without consultation of a medical officer.
* Another consumer was admitted to the service on a palliative pathway which the service did not immediately initiate. The consumer’s care planning documents did not have clear pain management strategies and there was limited evidence to demonstrate their pain was monitored to give them a pain free end of life and maximise their comfort. Care was also provided inconsistently with the wishes of the consumer’s representatives and no re-consultation of the consumer or their representative’s wishes was undertaken.
* A third consumer’s representative wished for their loved one to remain at the facility during their end of life stage. However, the consumer was sent to hospital post fall where they commenced palliative pathway and was directed by the medical officer to remain in hospital despite the end if life wishes. There was no re-consultation with the representative during this process.

The provider’s response addressed some of the deficiencies identified above:

* For the first consumer, a medical officer was consulted however it is unclear from the evidence if this was in relation to the increase in oxygen level for the consumer. However, the Assessment Contact – Site report did not bring forward sufficient information in relation to the consumer’s end of life needs, goals and preferences and whether this was recognised and addressed. Therefore, I am unable to form a view and have not considered this example.
* For the second consumer, the response stated they had not been referred to palliative care before being admitted to the service. In the response the provider maintains the consumer was appropriately reviewed and assessed for their care needs, end of life wishes was discussed with the consumer’s representative and palliative care medication was prescribed. The response provided evidence that when the consumer said they were in pain, pain relief was provided. However, the response does not address whether pain relief provided was in line with the consumer and/or their representatives end of life wishes and whether pain was consistently monitored to prevent the consumer from experiencing pain.
* For the third consumer, attempts were made to respect their wishes but this was overruled by the medical officer. Evidence provided in the response does not clearly support this.

The provider’s response outlined actions take to address the deficits identified and while I acknowledge these actions, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The evidence brought forward under this Requirement demonstrated end of life wishes were not always followed. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(c) non-compliant.

**Requirement 3(3)(d)**

The Assessment Contact – Site report identified deficiencies in relation timely identification and management of deterioration. The report brought forward the following examples to highlight the deficiencies:

* A consumer’s pain and toileting schedule was not followed in line with recommendation and not monitored to identify any deterioration.
* One consumer’s incontinence was worsening and there was no assessments conducted in relation to their ongoing incontinence issues to consider relieving some symptoms and addressing their current needs.

The provider’s response acknowledged the deficiencies identified in relation to the first mentioned consumer and stated the service intends to provide staff with further education in relation to adhering to the consumer’s toileting schedule. The response does not address the second consumer.

While I acknowledge the service has taken some appropriate actions to address some of the deficiencies, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The provider’s response also does not adequality address all deficiencies. The evidence brought forward under this Requirement demonstrated the service does not recognise the response to deterioration in a timely manner. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(d) non-compliant.

**Requirement 3(3)(e)**

The Assessment Contact – Site report identified care and services plans did not provide personalised information about consumers’ needs goals and preferences and interventions to meet those needs and goals did not provide sufficient guidance to staff. The report brought forward the following examples to highlight the deficiencies:

* Recommendations by dietician was not included in a consumer’s care plan and the dietary requirements was not provided to catering staff who confirmed they were not aware of the consumer’s special dietary requirements.
* Another consumer’s care planning document had limited guidance for staff to support the consumer’s eating disorder. The consumer also had a sleep assessment completed which stated the consumer has difficulties sleeping due to their condition but this was not included in the consumer’s care plan. In relation to the consumer’s skin management, their care plan stated they are at risk of pressure injury and staff said the consumer has an air mattress but this was not recorded in the consumer’s care plan. The care plan also does not include recommendations from a wound specialist.
* A third consumer had wandering behaviours and their behaviour support plan identified a number of behaviours and triggers, however it did not include interventions to manage those behaviours including recommendations made by an external organisation. The consumer’s mobility assessment also did not consider recommendations by a physiotherapist.

The provider’s response addressed some of the deficiencies identified above:

* The response acknowledged the first consumer’s care planning documents were not updated post review by the dietician and this has since been completed and communicated to catering staff.
* For the second consumer, care planning documents provided clear directions to staff on how to manage the consumer’s eating disorder. However, no evidence of this was provided in the response. The response did provide evidence of the consumer’s sleep assessment being reflected in their sleep care plan. In relation to the recommendation by the wound specialist, the response stated the consumer’s wound assessment was updated but does not clarify if this included recommendations by the wound specialist.
* Interventions were updated in the third consumer’s behaviour support plan. From the evidence provided in the response, progress notes included interventions however these do not appear to be reflected in the consumer’s behaviour support plan. The response also did not clarify if the recommendation made by the physiotherapists have been considered in the consumer’s mobility assessment.

The provider’s response outlined actions take to address one of the deficits identified however other deficits were not adequately addressed. The evidence brought forward under this Requirement demonstrated information about consumer’s condition, needs and preferences is not always documented and communicated. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(e) non-compliant.

**Requirement 3(3)(f)**

Care planning documents evidenced timely referrals to specialists and other providers of care and services. Management described improvements made to provide consumers access to a physiotherapist including providing telehealth consultations until the recruitment of a physiotherapist who cane commence face-to-face consultation.

# Standard 6

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| Feedback and complaints | |  |
| 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

The Service was found non-compliant in Standard 6 in relation to Requirements 6(3)(c) and 6(3)(d) following a site audit in April 2022. Evidence in the Assessment Contact – Site report dated 22 to 23 November 2022 supports that the Service has implemented improvements to address the non-compliance and is now compliant with both Requirements.

**Requirement 6(3)(c)**

Consumers who raised concerns with management said they received an apology and changes were implemented to address their concerns. Management and staff demonstrated an understanding of principles of open disclosure and the process that is followed when feedback and complaints are received. Improvements made since the finding of non-compliant after the Site Audit in April 2022 included additional education to staff on complaints and the open disclosure process and reminding staff to record and escalate informal verbal feedback.

**Requirement 6(3)(d)**

Management described how complaints are escalated and used to improve the care and services available to consumers. Staff described improvements, which were driven by consumer feedback. Improvements made since the finding of non-compliant after the Site Audit in April 2022 included revision of all policies, systems and procedures for complaint management, trending and analysing complaints and discussing these at staff meetings and escalating to the board.

# 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)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Service was found non-compliant in Standard 7 in relation to Requirements 7(3)(a), 7(3)(c), 7(3)(d), and 7(3)(e) following a site audit in April 2022. Evidence in the Assessment Contact – Site report dated 22 to 23 November 2022 supports that the Service has implemented improvements to address the non-compliance and is now compliant with Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e).

**Requirement 7(3)(a)**

Consumers acknowledged the service could do with additional staff, but despite this, they said they were well cared for and staff attended to their needs in a timely manner. Management described contingency plans in place to replace staff when required and rosters are reviewed on an annual and as required basis. Staff said there have been improvements in reducing unfilled shifts. Improvements made since the finding of non-compliant after the Site Audit in April 2022 included recruitment of additional staff and analysis of call bell reports to investigate and escalate long wait times.

**Requirement 7(3)(c)**

The Assessment Contact – Site report brought forward the following deficiencies:

* The service did not have a wound policy that outlined roles and responsibilities, including who treats and reviews complex wounds.
* Staff roles and responsibilities are still in development due to new policies and procedures being individualised.
* Staff were not able to demonstrate effective management of assessment and planning, palliative care, falls, pain, continence, provide effective behaviour support, or appropriately identify deterioration in consumers. As no further information or evidence was provided in the report to demonstrate lack of staff competency resulted in ineffective management of the areas listed, I am unable to form a view and have not considered this example. Ineffective management of the areas listed has been discussed and considered under other relevant requirements.

The Assessment Contact – Site report also outlined improvements the service has undertaken in relation to this Requirement. This included additional training for all staff across the Quality Standards and clinical subjects and recruitment of new staff who have sufficient knowledge and qualifications to perform their roles.

The provider’s response stated the service’s wound policy is under development however in the meantime the service is guided by an emergency manual which does set out wound management and outlines the types of wounds and who they should be referred to.

Though staff roles and responsibilities are currently being development, no evidence was brought forward that staff are not aware of their roles and responsibilities. I have also given weight to the consumer feedback outlined in the Assessment Contact – Site report which was positive in nature and no concerns were raised in relation to the competency or knowledge of staff to effectively perform their roles. Staff also did not express any concerns and were aware of the support available, such an on call registered nurse, should they have any concerns on how to effectively perform their role. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(c) compliant.

**Requirement 7(3)(d)**

Consumers did not identify any area where they thought staff requirement more training and expressed satisfaction in the care and services delivered by staff. Training records evidenced staff had completed required mandatory training and this was confirmed by staff. Improvements made since the finding of non-compliant after the Site Audit in April 2022 included creation of a mandatory training matrix and monthly check of staff completion.

**Requirement 7(3)(e)**

The Assessment Contact – Site report identified staff performance appraisals were not up to date, and that feedback provided through performance appraisals is not identified, monitored, reviewed, and implemented. The report brought forward the following examples to highlight the deficiencies:

* Management advised they have met informally with staff but have not conducted formal performance appraisals.
* An informal list of education and training requests from staff’s informal appraisal sessions has been collated but has not yet been incorporated into the training calendar.

The provider’s response addressed the deficiencies identified above and provided clarifying information in support of compliance:

* Formal performance appraisals had occurred for 2021/2022 however due to the employment of a new member of management the process was not as formalised as it had been in the past. Nevertheless, each team member had been provided with the opportunity to be reviewed and assessed. The response also stated that staff with performance issues were managed with improvement plans implemented. However, it is noted that the response did not provide evidence to support these claims.
* The response included an education calendar which incorporated training that were requested by staff through the information appraisal process.

While no formal performance appraisal process has occurred, I am persuaded by the provider’s response which demonstrated that staff are regularly assessed, monitored and reviewed and this is demonstrated in the education calendar reflecting requests for training as a result of informal appraisals. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(e) compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 8(3)(d) is non-compliant.

The Service was found non-compliant in Standard 8 in relation to Requirements 8(3)(a), 8(3)(b), 8(3)(c), and 8(3)(d) following a site audit in April 2022. Evidence in the Assessment Contact – Site report dated 22 to 23 November 2022 supports that the Service has implemented improvements to address the non-compliance and is now compliant with Requirements 8(3)(a), 8(3)(b), and 8(3)(c). However, improvements have not been effective and I find the Service non-compliant with Requirement and 8(3)(d) and have provided evidence and reasoning below.

**Requirement 8(3)(a)**

Management provided examples of different ways the service incorporates consumer feedback and suggestions into changes implemented to care and services at the service and organisational level. Consumers said they are invited to participate in consumer meetings to provide feedback in relation to different aspects of care and services, for example activities, food and furniture and décor at the service. Improvements made since the finding of non-compliant after the Site Audit in April 2022 included implementation of several consumer focus groups.

**Requirement 8(3)(b)**

Management and a member of the board provided examples of how the board monitors the service is compliant with the Quality Standards. The governing body ensures it is accountable for the delivery of care and services across the organisation by meeting regularly to review and discuss audit findings and provide instructions to management to meet service objectives. Improvements made since the finding of non-compliant after the Site Audit in April 2022 included various education to management and the board on their responsibilities, the Quality Standards and governance.

**Requirement (8)(3)(c)**

The Assessment Contact – Site report identified the service was unable to demonstrate effective governance systems in relation to information management, and workforce governance. The report brought forward the following examples to highlight the deficiencies:

* Care plans contain generic or incomplete information. This has been considered under Requirement 2(3)(b) where it is relevant.
* Staff were not able to demonstrate effective management of assessment and planning, palliative care, falls, pain, continence, provide effective behaviour support, or appropriately identify deterioration in consumers. As no further information or evidence was provided in the report to demonstrate lack of staff competency resulted in ineffective management of the areas listed, I am unable to form a view and have not considered this example. Ineffective management of the areas listed has been discussed and considered under other relevant requirements.
* The organisation procured generic policies and procedures from a peak body, which are being adapted and personalised for use at the service. Due to this, staff do not have access to information to assist in falls management, palliative procedures, incident and wound management.
* Requirement 3(3)(a) identified one consumer whose psychotropic medication was increase without consent from the consumer or their representative. However only one example was brought forward and it does not appear to be a systemic issue of noncompliance with restrictive practices regulatory requirements.

The provider’s response stated the service is revising policies and other documents to assist and guide staff. In the meantime, the service is guided by an emergency manual which sets out best practice information in relation to various aspects of care and services.

The Assessment Contact – Site report also outlined improvements to meet compliance that the service has undertaken following a site audit in April 2022 which identified deficiencies in relation to continuous improvements, regulatory compliance and feedback and complaints.

The evidence presented under this Requirement is insufficient alone to support that there is ineffective organisation wide governance systems. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(c) compliant.

**Requirement 8(3)(d)**

The Assessment Contact – Site report identified deficiencies in relation to ineffective risk management systems to manage high impact or high prevalence risks and manage and prevent incidents. The report brought forward the following examples to highlight the deficiencies:

* The service did not demonstrate effective care assessment and planning is undertaken to ensure high impact or high prevalent risks are identified and strategies implemented to manage those risks. Incidents are also not analysed to identify high impact or high prevalent trends.
* The service did not demonstrate that incidents, including reportable incidents through the Serious Incident Response Scheme, are investigated to identify causes and preventative measures are not developed.

The Assessment Contact – Site report also outlined improvements the service has undertaken in relation to this Requirements, including staff education on incident management and responsibilities in relation to reporting incidents and procurement of new policies and procedures.

The provider’s response addressed some of the deficiencies identified above:

* In relation to effective management of high impact or high prevalent risks:
  + The service does track each consumer to identify individuals who have high impact/ high prevalent risks.
  + Since new management has commenced at the service, data is reviewed and analysed monthly. However, no evidence was provided in the response to support this.
* In relation to investigating incidents, the response stated further education and monitoring will be provided to clinical staff in relation to incident management.

While I acknowledge the service has taken appropriate actions to address some of the deficiencies, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The evidence brought forward under this Requirement demonstrated the service does not have effective risk management systems to manage high impact or high prevalent risks and to manage and prevent incidents. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(d) non-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)