Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Ny-Ku Byun (new service) |
| Service address: | 1 Fisher Street CHERBOURG QLD 4605 |
| Commission ID: | 5780 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Site Audit |
| Activity date: | 13 December 2022 to 15 December 2022 |
| Performance report date: | 10 February 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 Ny-Ku Byun (new service) (**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 16 January 2023 including:
* A Plan for Continuous Improvement
* Care documentation relating to named consumers
* Staff training records for variable dose and psychotropic medication administration
* Staff training programs for restrictive practices, code of conduct and how to record care needs, monitoring or delivery within electronic care management system
* Policies and procedures relating to charting of wound management, food and fluid intake, catheter management and restrictive practices.

# 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 | **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 3(3)(a)** - The service ensures that care delivery in relation to restrictive practices, wounds and pain is managed in line with best practice, tailored to the needs of consumers to optimise their health and wellbeing.
* **Requirement 3(3)(b)** - The service implements procedures and practices to effectively identify and manage high impact or high prevalence risks associated with the care of consumers, including but not limited to falls, pain, restrictive practices, and the administration of medication.
* **Requirement 7(3)(d) -** The service improves the provision of and monitoring of training provided, including key risk areas to ensure the outcomes of these Quality Standards are achieved.
* **Requirement 8(3)(c)** - The service implements governance systems which applies and controls information management, regulatory compliance, and the workforce and monitors these systems to ensure they are effective and sustainable.
* **Requirement 8(3)(d)** - The service improves risk management systems to ensure high impact or high prevalence risks are appropriately managed and incidents including those classified as serious, are appropriately identified, reported, monitored and investigated to minimise further reoccurrence.
* **Requirement 8(3)(e) -** The organisation educates staff about the clinical governance framework, specifically policies on restrictive practice.

# 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 they were treated with dignity and respect, felt accepted and valued, and did not experience discrimination. Staff described what treating consumers with dignity and respect meant in practice. Policies and procedures reflected the organisation’s commitment to diversity and the consumer's right to have their dignity maintained and to be treated with respect.

Consumers advised staff delivering care and services knew what to do to make sure they felt respected, valued, and safe. Staff explained many of the consumers expressed a preference for care to be provided by same-gendered staff, and both men and women were rostered at all times to support consumer preferences. Policies, procedures, and guidelines had an inclusive, consumer-centred approach to care and service delivery.

Consumers said they have as much control over the planning and delivery of care and services as they wish, and the service supported them to make or change decisions affecting their health and well-being at any time. Staff were observed to support and help consumers make day-to-day choices about care, activities, and meal selection.

Consumers and representatives said the service understood what was important to consumers and confirmed being involved in decisions regarding risk. Staff explained how the organisation supported consumers to have choice and control over activities which presented a level of risk. A risk assessment was undertaken, and risk minimisation strategies were developed in consultation with consumers who wished to take risks.

Consumers and representatives said they generally received information about how services are delivered in a way they could understand. Staff described different ways information was communicated including strategies to communicate information to consumers with cognitive or sensory deficits. Accurate, timely and relevant communication was observed to be communicated to each consumer in a way that meets their needs.

Consumers positive feedback about how care and services were undertaken in a way which respected their privacy and kept their information confidential. Staff gave examples of how they maintain the privacy of individuals. Staff were observed to knock on the door and ask the consumer's permission prior to entering their room and closing doors before delivering care.

# 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 said they were partners in the care planning processes. Staff described the care planning process, and how it informed the delivery of care and services by identifying risks to consumer such as choking and pressure injuries. Care planning documentation showed assessments were completed and included consent to support risk-taking in line with consumers’ wishes.

Consumers and representatives said staff speak to them regularly about their care needs and their end of life wishes are only discussed when culturally appropriate and in line with their preferences. Staff demonstrated knowledge of the indigenous cultural aspects which need to be considered when consumers were approaching the end of life. Care documentation supported some consumers had provided instruction on their end of life wishes.

Care planning documentation evidenced the involvement of the consumer as well as a range of external providers including but not limited to physiotherapists, behavioural specialist services, mental health services, and optometrists. Consumers said they were involved in care planning and review processes. Staff were aware of the other people consumers wished to be involved in their care planning.

Staff advised they communicated the outcomes of assessments to consumers by talking to consumers and representatives and providing copies as requested. Consumers and representatives offered positive feedback about discussions they had with staff regarding any changes or concerns and said whilst they could not recall being offered a copy of the care plan, they felt staff communicated care planning outcomes with them. The service uses an electronic care planning system that incorporated assessments, charting, progress notes, and care plans.

Consumers were confident the service would make any changes to their care routines in consultation with them and their representatives to meet their needs, goals, and preferences. Management advised, and reviewed reports demonstrated, incidents were reviewed to identify strategies to minimise the risk of reoccurrence and to identify opportunities to improve outcomes for consumers.

# 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. | 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

The assessment team recommended Requirement 3(3)(a) and Requirement 3(3)(b) were not met. I have considered the assessment team’s findings; the evidence documented in the site audit report and the provider’s response and have found:

While consumers and representatives provided positive feedback about the care and services delivered, the service was not able to demonstrate they consistently provided care in accordance with assessed need. The high-impact or high-prevalence risks associated with the care of consumers, particularly relating to restrictive practices, complex care, nutrition and hydration, medication, falls and wound management were not being effectively managed as key risks and interventions were not consistently identified in the care documentation and where interventions had been documented, care was not being delivered tailored to the needs of those consumers.

For restrictive practices, these were not always identified as restraint and for one named consumer, subject to chemical and mechanical restrictive practices, there was no evidence of consent, authorisation, monitoring when restrictive practices were in used or that the restrictive practices were used as a last resort. Additionally, the three medications identified as used as chemical restraint was administered at higher doses than prescribed and in conjunction with each other, without evidence the consumer was displaying any signs of agitation for which the medication was indicated. Furthermore, additional doses were identified as administered, however, were not recorded as given on the consumer’s medication chart.

When consumers were identified to have a wound, electronic wound charting was completed inconsistently resulting in inaccurate monitoring of the progress of wounds, treatment regime not being followed and routine dressing changes unable to be evidenced with bandages observed to be showing signs of breakthrough.

For 5 consumers prescribed narcotic pain relief, staff confirmed during a two-week period, pain relief was unable to be provided to consumers as stocks had been exhausted and were unable to be resupplied, as the Medical officer was on leave and the pharmacy did not have the required repeat prescription. Staff confirmed this had negatively impacted consumers as they had required additional mobility support and were also observed during the Site Audit to be grimacing in pain while mobilising.

In relation to high impact or high prevalence risks, consumers who required catheter care, did not have a catheter care plan in place and staff were unable to demonstrate knowledge of when the catheter had last been changed. For 2 consumers, who required their food and fluid intake to be monitored to either prevent fluid overload, or ongoing unplanned weight loss, care documentation evidenced this had been completed sporadically or omitted in its entirety resulting in the actual intake, for both consumers, being unable to determined.

In relation to another named consumer, they were being a administered a variable dose blood thinning medication, with the amount of medication required dependent on the results of pathological testing, however, review of the consumers medication chart identified, pathological tests results had been archived, the dose being administered was inconsistent with the results and staff were not signing the medication had been administered.

The provider’s response submitted on 16 January 2023 acknowledged the deficits and submitted a plan for continuous improvement which outlined the corrective actions taken, commenced, or planned, including ensuring restrictive practices were reviewed and updated to reflect the current assessed needs. Clinical processes had been re-established to monitor the delivery and management of consumers clinical needs to ensure directives were followed and monitored.

Additionally, strategies to immediately reduce the risk to consumers have included deployment of additional clinical support to assist with the assessment of clinical care needs and provide support, monitoring and training to the registered staff. Further improvement actions have been identified as providing the Medical officer with access to the electronic care system to ensure staff are aware of their directives in a timely manner and a management system has been implemented to guide the administration of variable dose medication.

While the provider has commenced the implementation of these corrective actions, I find, at the time of the site audit, the service was not able to demonstrate high-impact risks were effectively managed, nor was safe, effective or tailored clinical care provided to each consumer.

Therefore, I find Requirement 3(3)(a) and Requirement 3(3)(b) are non-compliant.

I find the remaining 5 requirements of Quality Standard 3 compliant as:

Care documentation detailed advance care planning information, including consumer’s choices about end-of-life preferences. Staff gave examples of how care changed when a consumer approached end of life and confirmed the care required to keep a consumer comfortable. Staff said they had access to the hospital palliative specialists, end-of-life medications and syringe drivers, and on-call GPs to support consumers to be pain free.

Consumers and representatives said they were happy with the delivery of care including the recognition of deterioration or changes in their condition. Staff advised the clinical staff were responsive when they reported any changes in consumers' conditions. Care planning documentation demonstrated where deterioration in a consumer’s health, capacity, and function was reported, it was escalated and followed up appropriately.

Consumers and representatives said changes to consumers’ condition were communicated amongst staff. Staff described and handover documentation confirmed information about changes to the consumer’s condition, and upcoming appointments were shared with the incoming shift and family/next of kin to monitor and follow up. However, delays were identified in the sharing of information between the medical officer and staff, as the medical officer did not have access to the electronic care management system to record care directives following review of consumers.

Staff explained the process for referring consumers to health professionals and allied health services. Care planning documentation reflected referrals to a range of allied health professionals and included input and recommendations from other providers of care such as physiotherapists, speech pathologists, and dieticians. Consumers and representatives confirmed they were referred to other providers when required.

Consumers and representatives gave positive feedback about the service’s management of COVID-19 precautions and infection control practices. Staff said they had received training on infection-minimising strategies including hand hygiene, the use of appropriate personal protective equipment, and outbreak management processes. Staff demonstrated an understanding of how to minimise the need for antibiotics and ensure they are used appropriately. Hand sanitising and personal protective equipment stations were observed located throughout the service.

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

Findings

Consumers described how they were able to optimise their independence, contributing to their health, well-being, and quality of life. Care planning documentation identified the individual services and supports consumers needed to do the things they wanted to do. Staff explained what was important to consumers, what they liked to do, and this information aligned with consumer’s care plan.

Consumers said their spiritual and psychological well-being was supported as they were engaged in activities important to them. Care planning documentation recorded consumers’ individual emotional support strategies and how these were implemented. Staff acknowledged the importance of spiritual connection and described everyday activities which embraced the local and Indigenous culture.

Consumers felt supported to participate in activities within the service and outside the service as they chose. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer. A monthly newsletter kept all consumers and representatives, as well as the local community, up to date with what their elders were doing which had resulted in increased visitation and community participation.

Consumers said staff were aware of their needs and preferences and they did not have to repeat their preferences to multiple staff members. Staff discussed ways in which they shared information and were kept informed of the changing conditions, needs, and preferences of each consumer. Care documentation provided adequate information to support safe and effective care as it related to services and supports for daily living.

Consumers’ care planning documentation showed the service collaborated with external providers to support the diverse needs of consumers. Consumers and staff provided examples of referrals to external providers of care and services including disability support organisations. allied health services and specialist support services.

Consumers said the service provides varied meals, of suitable quality and quantity. Staff described how individual consumer’s dietary needs and preferences were recorded and supported including through a regular barbeque to meet consumer's meal preferences. Meal service was observed and staff were seen to chat with consumers and attend to their individual preferences, in line with consumers documented choices.

Consumers advised they felt safe when using the service’s equipment and believed staff were skilled in using the equipment such as lifters. Equipment used for activities of daily living was observed to be clean and safe, suitable, and well maintained. Staff confirmed preventative and reactive maintenance processes were in place and an external contracted company regularly reviewed and conducted repairs to all mobility support equipment.

# 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

Staff described how consumers were supported to make the facility feel like home, and how they supported consumers to maintain independence. The environment was observed to be easy to navigate, and consumers could make their way around the service with ease. Consumers were encouraged to personalise their rooms, with local Indigenous and consumer artworks adorning the walls.

Consumers and representatives said, and observations confirmed, the facility was clean, and maintenance was completed quickly. Consumers were observed to be moving freely around the lounge and dining rooms, hallways, and gardens. Planned and preventative maintenance was conducted to ensure the consumers were safe and living in a well-maintained home.

Consumers said equipment was well maintained, clean, and requests for repairs were addressed promptly. Staff said they had access to the equipment needed for consumer care and explained organisational and service-initiated audits were in place to ensure the service was clean, safe and comfortable for consumers, staff and visitors. Equipment, furniture and fittings were observed to be clean, well maintained, and suitable for use.

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

Findings

Consumers confirmed they were encouraged and supported to make complaints and provide feedback and had no issues talking with staff or management should they have a concern. Staff reported they were aware of the complaints processes, however, they mostly received verbal feedback from the consumers. A comments and complaints box was available for confidential feedback and complaints information was displayed or contained in publications.

Consumers and representatives said they were aware of other avenues for raising a complaint, such as through the Commission, or advocates, however, they were comfortable raising concerns with staff. Staff demonstrated a shared understanding of the complaints processes and described how families and representatives assist consumers who have difficulty communicating to raise a complaint or provide feedback. The service’s written materials, such as the consumer handbook, included contact information for external complaint and translator services.

Consumers and representatives said management promptly addressed and resolved their concerns following the making of a complaint, or when an incident occurred, and confirmed an apology was given. Management explained the process followed when feedback or a complaint was received. Staff demonstrated knowledge of the principles of open disclosure as they had completed open disclosure training.

Consumers and representatives had several ways to provide feedback or make a complaint and all complaints were logged and recorded. Staff advised every comment and complaint, whether it was received on the feedback form, through a survey, provided verbally or via email, was acknowledged and responded to promptly. Documentation reviewed evidenced feedback and complaints were linked to the continuous improvement plan.

# 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. | 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 recommended Requirement 7(3)(d) was not met. I have considered the assessment team’s findings; the evidence documented in the site audit report and the provider’s response and have found:

The Site Audit report evidenced deficiencies in the provision of mandatory training with some staff advising they had not received training in the Code of Conduct for Aged Care or serious incident reporting with care staff unable to describe their obligations under the serious incident response scheme (SIRS).

Furthermore, registered staff sourced through an agency to replace staff on planned or unplanned leave, did not understand their legislative requirements for the management of restrictive practices or demonstrate knowledge of safe practices in medication management, resulting in the incorrect use of chemical restraint and variable dose medication being given incorrectly. In addition, there were no records to support agency staff had completed and successfully passed orientation, including being able to use of the service’s electronic clinical management system.

The provider’s response acknowledged the deficits and submitted a plan for continuous improvement which outlined a range of corrective actions that have been taken, commenced, or are planned to address the deficits evidence in the Site Audit report.

I acknowledge the provider has identified confusion with some of the terminology used and they have advised all permanent staff had received training titled ‘Consumer Protection’ which covered topics including mandatory reporting. The provider stated, although staff may not have recognised the acronym SIRS, the staff were committed to advocating for, and ensuring no harm befell the consumers at the service and the provider believed processes followed were in accordance with the principles of SIRS.

The provider advised they have informed the agency, contracted to provide casual staff, of their expectations on the knowledge and capacity of staff supplied to the service and the staff orientation folder and staff handbook have been updated to provide consistent information, including about SIRS.

Based on the evidence before me, I consider, at the time of the site audit, the service was unable to demonstrate staff were trained, equipped, and supported to deliver the outcomes required by these standards and the improvements outlined by the service will take time to embed and monitor for their effectiveness.

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

I find the remaining 4 requirements of Quality Standard 7 compliant as:

Consumers said staff were available to meet their needs, describing them as hardworking and confirmed they respond promptly to calls for assistance or verbal requests. Rostering documentation evidenced a mix of staff including registered nurses, personal carers, and hospitality services are routinely allocated and processes are in place to replace staff on unplanned leave. Call bell data showed staff attend to calls for assistance in under 5 minutes.

Staff were observed addressing consumers by their preferred names and taking the time to speak to and interact with consumers, in a kind and caring manner. Staff demonstrated knowledge of consumers’ cultural, personal backgrounds and the activities undertaken to acknowledge the consumers’ cultural heritage. The staff handbook directed staff on appropriate workforce interactions with consumers and contained the Code of conduct.

Consumers and representatives sampled said that staff have the knowledge and skills to perform in their roles effectively and confirmed their needs were met. A register confirmed all staff had up-to-date qualifications and manual handling competencies were reviewed monthly. Staff confirmed buddy shifts were offered when they commenced and an increased number of buddy shifts are provided to staff yet to receive their formal qualifications to ensure their competence, however some gaps in staff competency in medication management and restrictive practices were identified.

Management said the performance of staff was formerly reviewed at least once a year using a formal appraisal process, however while all had been scheduled not all had been completed. Staff demonstrated awareness of the service’s performance review processes and confirmed this included discussion on their performance and areas where they would like further development. Senior staff were observed mentoring, providing ongoing support and guidance to less experienced staff as part of an informal performance review process.

# 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. | 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

The assessment team recommended Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e) were not met. I have considered the assessment team’s findings; the evidence documented in the site audit report and the provider’s response and have found:

In regard to Requirement 8(3)(c), the service did not have an effective organisation wide governance system to ensure the delivery of safe and quality care and services regarding information management, workforce governance, and regulatory compliance.

* Information Management

Whilst the organisation has systems in place to support staff to have access to the information required to provide care and services, information on restrictive practices was inaccurate and staff did not have ready access to the information required to perform their roles as training on the electronic care management system had not been provided and the medical officer had not been given access to the care management system in which to record their care directives following review of a consumer.

* Workforce Governance

While, a human resource management system, is in place to maintain employee information and monitor the currency of required qualifications and credentials, deficits were identified in the systems and processes to ensure staff understood their roles and responsibilities in relation to medication management, restrictive practices and recording of clinical documentation. While management had recognised deficiencies in the knowledge of permanent staff and had implemented ongoing support for staff, they had not recognised deficiencies in practice which had adversely impacted consumers.

* Regulatory compliance

Whilst the organisation has processes to monitor compliance with regulatory obligations, the service was not able to demonstrate its systems and processes effectively identified and met legislative requirements when chemical and mechanical restrictive practices had been applied when new consumers entered the service or new care strategies were implemented in response to high impact risks to consumers.

The provider’s response submitted on 16 January 2023 acknowledged the deficits identified in the Site Audit report and submitted a plan for continuous improvement which outlines the corrective actions taken, commenced, or planned, including assigning a registered nurse to enter the medical officer’s directives until access to and training in the care management system has been provided. Additionally, a full review of restrictive practices has been conducted, restrictive practices resources have been provided to staff and clinical staff meetings will include further discussion on the topic.

While the provider has commenced implementation of these corrective actions, they will take time to demonstrate their effectiveness and I find, at the time of the site audit, the service was not able to demonstrate effective organisation wide governance systems relating to continuous improvement, workforce governance, and regulatory compliance.

Therefore, I find Requirement 8(3)(c) is non-compliant.

In consideration of Requirement 8(3)(d), the site audit report evidenced the organisation had processes to identify and monitor high impact and high prevalence risks such as risk registers, however, audits and other systems or monitoring processes did not identify the inappropriate use of chemical restraint, ongoing medications errors, inconsistent monitoring of wounds and the poor management of food and fluid intake potentially placing consumers at risk.

The provider acknowledged in their response dated 16 January 2023 the opportunities to further strengthen the implementation of organisational risk management systems at the service and submitted a plan for continuous improvement which outlines the corrective actions taken, commenced, or planned, including providing education around restrictive practices, electronic charting and disseminating updated organisational policies and procedures to all staff.

While the provider has commenced the implementation of these corrective actions, I find, at the time of the site audit, the service was not able to demonstrate effective implementation of risk management systems and practices.

Therefore, I find Requirement 8(3)(d) is non-compliant.

In relation to Requirement 8(3)(e), the site audit report evidenced deficiencies in the service’s clinical governance framework as inappropriate use of chemical and mechanical restrictive practices was undetected and the documentation used to monitor restrictive practices was inaccurate and did not support an active approach to the minimisation of restrictive practices. Additionally, registered staff did not demonstrate, the need for consent or authorisation was understood, had inappropriately applied restrictive practices and were not aware of the need to minimise restrictive practices by using it as a last resort.

The provider acknowledged the deficiencies in their response dated 16 January 2023 and submitted a plan for continuous improvement which outlined the corrective actions taken, commenced, or planned, including completing a full review of restrictive practices used within the service with further minimisation options being explored and updating care plans and the restrictive practice folder to ensure consistency. Furthermore, staff have been provided with refresher training on restrictive practices.

While the provider has commenced the implementation of these corrective actions, these will take time to embed and demonstrate their effectiveness in improving the clinical governance of restrictive practices.

Therefore, I find Requirement 8(3)(e) is non-compliant.

I find the remaining 2 requirements of Quality Standard 8 compliant as:

Consumers and representatives said they provide ongoing input into how consumers’ care and services were delivered and confirmed the service regularly sought their input through consumer meetings, surveys, and face-to-face discussions. Management advised feedback or suggestions made by consumers and representatives were included in the service’s improvement register for investigation and actioning. Minutes of consumer committee meetings and the service’s plan for continuous improvement evidenced consumer input into and the evaluation of services.

The organisation uses information from consolidated reports to assess the service’s compliance with the Quality Standards; initiate improvement actions to enhance performance; and monitor care and service delivery. Policies, procedures and written material for consumers identified care is provided in an inclusive, person centred environment where diversity is valued.

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