Performance

Report

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| Name of service: | Regis Ringwood |
| Service address: | 294 Maroondah Highway RINGWOOD VIC 3134 |
| Commission ID: | 4289 |
| Approved provider: | Regis Aged Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 1 March 2023 to 9 March 2023 |
| Performance report date: | 19 May 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 Regis Ringwood (**the service**) has been prepared by G.Hope‑Simpson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit. The Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 19 April 2023.
* other information and intelligence held by the Commission in relation.

# Assessment summary

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| --- | --- |
| 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)(b) – The Approved Provider ensures the effectively monitor and manage risks associated with the care of each consumer, specifically oxygen therapy and complex behaviours.
* Requirement 7(3)(e) – The Approved Provider ensures regular assessment, monitoring and review of the performance of each member of the workforce, and maintains an accurate register of when these occurred and when they are due.
* Requirement 8(3)(c) – The Approved Provider ensures effective organisation wide governance systems are implemented and maintained.
* Requirement 8(3)(d) – The Approved Provider ensures the management of high-impact, high prevalence risks associated with each consumer are aligned with best practice guidelines.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Overall consumers and representatives said staff displayed dignity and respect towards consumers, and their diversity and culture was valued and celebrated. The Assessment Team found however one consumer felt staff did not always treat them with dignity and respect. I have considered this evidence in Requirement 3(3)(b). Staff were observed to speak about consumers in a respectful manner. Care planning documentation evidenced information on consumers’ identity, culture, and diversity.

Consumers said they received culturally safe care. Care and services delivered by staff took account of consumers’ cultural preferences and needs. The service’s Inclusivity Policy Statement guided staff in providing safe, inclusive, consumer-centred care to people from diverse backgrounds.

Consumers were supported to exercise choice, maintain their independence regarding how their care and services were delivered, and maintain connections and relationships of their choosing. Staff described ways they supported consumers to exercise choice, such as supporting consumers to attend to their hygiene care, when preferred.

Consumers said they were supported to take risks which enabled them to live their best lives. The service supported consumers to have control over and make choices about their care including where choices involved risk.

Consumers said information provided to them was clear and easy to understand. Staff described ways in which information was provided, including for consumers from a culturally and linguistic background. The Assessment Team observed lifestyle calendars and various aged care sector brochures displayed on noticeboards throughout the service.

Consumers said their privacy was respected, expressed confidence in the service to protect their personal information, and described staff practices such as knocking on doors prior to entry and closing the door during provision of personal care. The Approved Providers’ policy guided staff on the expectations of consumers privacy.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Care planning documents mostly reflected a comprehensive assessment and care planning process was undertaken to identify consumers’ needs, goals, preferences and risks. Where risks were identified, risk assessments were in place and risk mitigation strategies developed and implemented. Advance care and end-of-life planning were included in care plans and updated as the consumer’s care needs changed.

Care planning documents evidenced the involvement of consumers, representatives and other health professionals in the assessment and planning process. Management described how they partnered with consumers and representatives in the assessment and planning process, and said for consumers who are cognitively impaired or do not have a representative, clinical staff along with the consumer’s GP were involved.

Consumers and representatives said staff explain information about care and services, they can access a copy of the consumer's care and service plan when they want to. Staff described how they communicated outcomes of assessment and planning, including for consumers who have a diverse language background or were cognitively impaired.

Care plans were reviewed every 3 months or more frequently when changes in a consumer’s condition occurred.

# Standard 3

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

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

The Site Audit Report reflected most consumers receive effective personal care and clinical care that was tailored to optimise their health and well-being. Consumer and representative feedback, as well as care planning documentation showed the service generally managed high impact risks to consumers, including falls, pressure injuries and the use of restraints. However, the Assessment Team found deficiencies relating to management of oxygen therapy for one consumer, and management of complex behaviours for another.

For the deficiencies relating to management of oxygen therapy, a named consumer’s oxygen supply had been mismanaged resulting in their requiring medical attention on one occasion. The consumer’s oxygen levels had also not been checked regularly by staff. The consumer experienced lasting worry about how their risks were managed. For the deficiencies relating to the management of changed behaviours for one consumer, the Site Audit Report brought forward evidence the service failed to identify and respond to their changed behaviours over a prolonged period, resulting in recurrent distress and the consumer requiring offsite medical attention during the Site Audit. After this, and during the Site Audit, immediate steps were taken to address the consumer’s needs.

The Approved Provider responded on 19 April 2023 and acknowledged the opportunities for improvement in management of risks related to oxygen therapy and changed behaviour. The response included a Plan for Continuous Improvement (PCI), which demonstrated the service has identified appropriate actions to address these deficits and have commenced implementing them. The PCI contained plans to implement a process for monitoring the first consumer’s oxygen equipment and cylinders, and to conduct audits to ensure staff regularly check the consumer’s oxygen saturation levels. The PCI also contained a plan for further training of members of the workforce on oxygen management, and further education for clinical staff on how to respond to, manage and report complex consumer behaviour. Lastly, the PCI outlined steps that had been taken to improve the service’s management of the second named consumer’s changed behaviour, noting engagement with the consumer’s Medical Officer (MO), a dementia service and the consumer’s next of kin.

While I acknowledge the appropriate improvement actions taken during the Site Audit itself and those outlined in the service’s PCI and response, I am satisfied that at the time of the Site Audit, the service did not consistently demonstrate effective management of high impact and high prevalence risks for the two named consumers. The service has committed to a continuous improvement process to address these deficits; however, insufficient time has passed for the improvement actions to be implemented in full, become embedded practice and be measured for effectiveness. Therefore, I find that at the time of writing this Performance Report, the service remains non-compliant with Requirement 3(3)(b).

Regarding the remaining Requirements: overall, consumers and representatives said the service provided safe and effective clinical care that addressed their needs. The service had processes in place to manage restrictive practices, skin integrity and pain management. However, the Assessment Team identified members of staff did not have shared understanding of who bore responsibility for aspects of stoma management and documentation deficits in the service’s psychotropic medication register were also identified, though there was no detrimental impact to consumers as a result of these deficits. Where relevant, the deficiencies were recorded on the service’s Plan for Continuous Improvement (PCI).

Care planning documents for consumers who were nearing end-of-life showed their needs, goals and preferences were recognised, and their comfort maximised. Representative feedback from consumers on palliative care during the Site Audit, said consumers were kept comfortable and pain free, and staff treated them with dignity. The service has an emphasis on constant communication with representatives as to the consumer’s condition, explanation of what is happening and what is expected during their end-of-life pathway.

Overall, consumers and representatives interviewed stated that the service was responsive to changes in a consumer’s presentation, and appropriate strategies are implemented to address signs of deterioration and discomfort. Staff considered they recognised and responded to deterioration or changes in consumers’ conditions and reported or escalated these as relevant. Care planning documents mostly supported deterioration was identified and strategies were applied if relevant to improve consumers’ conditions. While deficiencies in response to changed behaviours for one consumer were identified, these were most relevant to Requirement 3(3)(b), where they have been assessed.

Progress notes, care and service plans, and handover reports provided adequate information to support effective and safe sharing of consumers' care. Staff described how information and up-to-date conditions, needs, and preferences were documented in the service’s electronic care management system (ECMS) and also communicated through handovers, care planning forms and communication books.

The service had a network of approved individuals, organisations and providers they referred consumers to. Policies that identified triggers for referral were in place and consumers confirmed referrals were made in a timely manner. Care planning documents mostly reflected referrals to other health professionals were timely and staff understood the referral process.

Consumers and representatives sampled expressed that the service is clean, and staff are observed washing and sanitising hands regularly. All staff interviewed, including management, clinical staff and PCAs, were able to provide examples of infection control practices used at the service. The service had documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. The service was supported by a Regional Infection Prevention and Control (IPC) Lead, as it was discovered during the time of the Site Audit that the service could not produce evidence of IPC qualifications.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Services and supports for daily living met consumers’ needs, goals and preferences and optimised their independence and quality of life. Care planning documents were strength based, included information about what was important to consumers, and supports needed to do the things they liked to do. The service had established assessment processes to determine consumers’ needs, preferences, and goals to enhance their independence and quality of life.

Consumers stated their emotional, spiritual and psychological needs were supported and care planning documents included strategies to meet these needs. Staff understood the importance of culturally tailored, emotional, psychological and spiritual support for consumers and services provided were meaningful to consumers.

Consumers participated in the community within and outside the service, had social and personal relationships, did things of interest to them, and kept in touch with people important to them. During the Site Audit, the Assessment Team observed families visiting and spending time with consumers in their rooms or in the various outdoor and indoor communal areas.

Consumers considered information was adequately communicated between staff. Staff described how communication of consumers’ dietary and daily living needs and preferences occurs via care planning documents, shift handover and through the service’s ECMS.

Regular, timely and appropriate referrals were made to other individuals, organisations, and providers of care where required. Care planning documents showed the service collaborated with external services to support the needs of consumers. This was confirmed by consumer feedback.

Overall consumers expressed satisfaction with the quality and quantity of the food. The Assessment Team observed meals which looked and smelled inviting, assistive cutlery and crockery were available for consumers, and staff were assisting consumers with their meals in a dignified manner. The service was committed to continually reviewing and improving the dining experience of consumers, through the use of consumer feedback.

Equipment for daily living and lifestyle supports were observed to be safe, suitable, clean and well maintained. Consumers said their equipment, is well maintained. Management and staff described the process for checking and cleaning equipment, and reporting any faults.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service environment was observed to be welcoming and safe, with handrails available to optimise independent mobility, and spacious corridors for mobility aids. Staff described how consumers were supported to personalise their rooms with furniture and photos to promote a sense of belonging and independence. Consumers said the service allowed them to maintain their independence, interaction and they had a sense of belonging.

Consumers said the service environment was safe, clean and well maintained, and allowed them to move around freely. The service had a preventative maintenance schedule which included room audits on a bi-monthly basis. The Assessment Team observed cleaning staff attending to a consumer’s room during the Site Audit, and consumers accessing different common areas.

Furniture, fittings, and equipment were observed to be safe, clean, and suitable. Consumers and staff confirmed sufficient equipment was available. Staff described how shared equipment was cleaned and maintained.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Assessment Team recommended the following requirements were not met:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

Relevant (summarised) evidence brought forward in the Site Audit Report is outlined as follows. The Assessment Team found feedback and complaints were not used to improve quality of care and services. The Team considered the service’s PCI and follow up action recorded in it did not reflect issues in complaints trends, and planned improvement actions were not implemented. One consumer representative felt their feedback had not resulted in improved quality of care for the consumer, and they provided repeated written complaints regarding the same issue as a result. Management and clinical staff said care and service improvements including staff undertaking reactive training had been made in response to feedback and complaints, and said data was analysed to inform care and service improvements. The Assessment Team found however, training records did not evidence reactive education was provided to members of the workforce, as review of the service’s PCI identified only 13 items had been listed, with only one in response to consumer feedback. The report also the organisation’s method of identifying training needs had changed and that training delivery was now standardised across the organisation.

The Approved Provider responded on 19 April 2023 and disagreed with the findings in the Site Audit Report. The response included extensive additional information and documentary evidence in response to the Assessment Team findings, which showed that the service had implemented improvements to care and services in response to the named consumer representative’s complaint. The response also included evidence that appropriate training for members of the workforce was provided in response to the feedback and that where further training was not appropriate, performance management was pursued instead. Additionally, the Approved Provider clarified that at the time of the Site Audit, the Assessment Team had requested a copy of the service’s current PCI. The Approved Provider acknowledged the PCI had only 13 items listed as it was the active PCI, and clarified that the Assessment Team did not review PCIs from previous years, which detailed additional completed improvement items arising from consumer feedback. Lastly, the response confirmed the new method for planning monthly training calendars allows for modules to be added in response to identified need, such as those identified through consumer complaints.

I accept the Approved Provider’s response and documented evidence and as a result, consider there is insufficient evidence to show the service did not use feedback and complaints to drive improvements at the service. There is sufficient documentary evidence to demonstrate the service implemented various trainings in response to consumer complaints, and that other improvements, including the purchase of food heating equipment, were also implemented in response to feedback. For these reasons, I have disagreed with the Site Audit Report recommendation and instead find the service complies with Requirement 6(3)(d).

Regarding the remaining Requirements: The service had multiple methods for consumers to provide feedback and make complaints including feedback forms, speaking with management and raising any issues of concerns at consumer meetings. Consumers confirmed they were encouraged and supported to provide feedback and make complaints.

Consumers and representatives said although they were aware of other avenues for raising a complaint, such as through the Commission, or an advocacy service, they were comfortable raising concerns with management and staff. Brochures and other written information in relation to advocacy and language services were provided on admission and displayed throughout the service.

Overall staff were aware of the underlying principles of open disclosure, including acknowledging when things go wrong, to apologise, and to use all complaints as opportunities for improvement. Most consumers and representatives confirmed the service responded in a timely manner when feedback was provided however, the Assessment Team found at times open disclosure had not been used and apologies were not given. There was a lack of familiarity among some senior management staff regarding their accountabilities and responsibilities in relation to open disclosure and complaints management, however on balance, the Assessment Team found Requirement 6(3)(c) was met.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| 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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

Although the service had a mandatory annual staff performance appraisal and management system in place to review and monitor staff performance, the Assessment Team found that regular performance reviews for most staff had not been undertaken. When asked, management were not able to provide detail about other ways the service monitors staff performance, in the absence of performance appraisals. Lastly, during the Site Audit, the service struggled to provide accurate information about outstanding performance appraisals in a timely manner.

The Approved Provider responded on 19 April 2023 and did not refute the Site Audit Report’s findings. The Approved Provider’s response demonstrated continuous improvement measures undertaken and planned, including registering the deficiencies on the service’s PCI, and developing a structured process of monitoring performance appraisals. The service’s PCI demonstrated the service had commenced completing outstanding appraisals and has an appropriate plan to ensure appraisals remain up to date in future.

I acknowledge the Approved Provider’s commitment to addressing the deficiencies. However, the service did not have an effective system in place prior to the Site Audit to demonstrate regular assessment, monitoring and review occurs for each member of the workforce. While improvement actions have commenced, at the time of writing this Performance Report; the performance appraisals are not yet up to date and new processes to ensure they remain up to date are not yet fully implemented. The service requires time to implement improvements, embed them and evaluate the actions to ensure they have been effective. As a result, I find the service is not compliant with Requirement 7(3)(e).

Regarding the remaining Requirements: Consumers and representatives considered staffing levels were adequate. The Approved Provider had effective rostering processes to deploy sufficient staff and replace absences. Call bell data identified call bells were answered promptly.

Consumers and most representatives said staff were respectful, kind and caring. The Assessment Team observed several kind and respectful interactions between staff and consumers, including staff addressing consumers by their preferred name.

Overall consumers and most representatives considered staff perform their duties effectively and they were confident staff were trained appropriately and were skilled to meet their care needs. Position descriptions set out the expectations for each role and recruitment processes include verification of minimum qualification and registration requirements.

Members of the workforce were trained, equipped and supported to deliver safe and effective care. Consumers and most representatives expressed confidence in the abilities of staff. Education records identified staff participated in mandatory training and most other training identified as required. The Assessment Team found however, the service’s training records did not evidence reactive training provided to staff as a result of feedback and complaints. This same evidence was considered and overturned in Standard 6. Additionally, the Assessment Team found the service’s Infection Prevention Control (IPC) Lead had not yet completed the required training. The service undertook remedial actions and acknowledged that as the service was not complying with its regulatory obligations, the service would be supported by a Regional IPC from the organisation until the Registered Nurse completed the course. On balance, the Assessment Team were satisfied the service complied with Requirement 7(3)(d).

# Standard 8

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

Findings

I have assessed these Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.

* 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.

Requirement 8(3)(c)

The Assessment Team found the service had functional governance systems in place for financial governance and regulatory compliance, but concluded that the governance systems for information management, workforce governance (as examined in Standard 7), feedback and complaints and continuous improvement (as examined in Standard 6) were ineffective. However, in Standard 6, Requirement 6(3)(d), I outlined my reasons for disagreeing with the Assessment Team’s finding the service did not use consumer complaints to effect continuous improvement. I rely on that reasoning to find here that the service’s continuous improvement and feedback and complaints governance systems are generally effective.

In relation to information management, the Site Audit report noted during the site audit, the service had extensive difficulties in providing accurate and current copies of consumer meeting minutes, staff meeting minutes, HR records, psychotropic, restrictive practices and vaccination registers, SIRS reporting history, performance appraisal and training rates.

The Approved Provider responded on 19 April 2023 and did not refute the Site Audit Report’s findings regarding deficits in governance systems for information management and workforce governance. The response contained a PCI, which showed continuous improvement measures to be undertaken, to address significant deficits in information management and management of performance appraisal processes. Planned improvement actions included an audit of all the service’s reports including but not limited to mandatory training, psychotropic register and performance appraisals. The PCI also contained an undertaking to provide education on reporting to relevant staff and to implement a scheduled process for monitoring and updating relevant registers on a routine basis.

I consider the examples brought forward by the Assessment Team support that the Approved Provider did not demonstrate effective governance systems for information management and workforce governance. As discussed previously, I was persuaded by the Approved Provider’s response to Requirement 6(3)(d) and relying on that reasoning, I find the service’s governance of feedback and complaints and continuous improvement to be generally, effective. However, as 2 of the relevant governance systems were not demonstrated to be operating effectively during the Site Audit and given the multiple improvement actions outlined in the PCI will require time to implement, embed and evaluate, I find the service does not comply with Requirement 8(3)(c) at the time of writing this Performance Report.

Requirement 8(3)(d)

The Assessment Team found this requirement was not met on the basis of ineffective management of risks for two named consumers, one who required oxygen therapy and one who had experienced changed behaviour over the course of one month and which were not being managed by staff. Refer to Standard 3 for details of this evidence. Although risk management systems and process were in place, high impact risks for these two consumers were not being appropriately managed. The not met recommendation in Requirement 8(3)(d) also relied on deficits in SIRS reporting, including the incorrect categorisation of incidents and lack of evidence to demonstrate the service consistently took appropriate steps to prevent recurrence of incidents.

The Approved Provider’s written response did not refute these findings. The PCI showed that since the Site Audit, the service has planned appropriate improvement measures to rectify the deficits identified. These included staff education on SIRS, use of the service’s incident management system and escalation processes. Other planned and implemented actions to address concerns relating to the two named consumers have already been outlined in Standard 3. While I acknowledge these continuous improvements measures, they have not been implemented in full. The service will require time to roll out education and to monitor and evaluate the effectiveness of the training in achieving sustained changes in practice. For these reasons, I am satisfied the service’s risk management systems were not effective, either at the time of Site Audit or at the time of writing this Performance Report. I consider the service’s ineffective risk management practices resulted in some detrimental consumer impact, as outlined in Standard 3. For these reasons, I find the service does not comply with Requirement 8(3)(d).

Regarding the remaining Requirements - The service was engaging consumers through a variety of mechanisms such as consumer and representative meetings, feedback forms and regular surveys. Although resident and relatives’ meetings minutes reviewed by the Assessment Team evidenced complaints and compliments were discussed, data from 3 previous meetings had been copied and pasted and did not reflect what had been discussed. Upon raising with management, they confirmed the error and advised the staff member responsible for minute taking had received interim training however formal training would be organised prior to the next meeting. Other examples of meeting minutes, however, did demonstrate that the service uses those forums to engage consumers in the development, delivery and evaluation of care and services.

Management described how the governing body is involved in the delivery of care and services as indicated in its organisational chart and outlined in its Organisational Governance Framework. A review of the framework indicated that the organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery with clear lines of reporting to the Board of Management.

The service had a documented clinical governance framework, which included policies, guidelines, service delivery requirements and staff training requirements relating to antimicrobial stewardship, minimising the use of restrictive practices and open disclosure. However, the Assessment Team found some deficiencies in application and understanding of framework, which have been outlined and considered in previous Requirements where they were more relevant. The service did have an Outbreak Management Plan and review of recent Pandemic Planning Committee Meeting minutes showed standard infection control was discussed.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)