Performance

Report

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| Name: | St George's Care Centre |
| Commission ID: | 7257 |
| Address: | 2 Essex Street, BAYSWATER, Western Australia, 6053 |
| Activity type: | Site Audit |
| Activity date: | 20 February 2024 to 23 February 2024 |
| Performance report date: | 19 April 2024 |
| Service included in this assessment: | Provider: 701 Amana Living Incorporated  Service: 5298 St George's Care Centre |

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 St George's Care Centre (**the service**) has been prepared by M Glenn, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management; and
* the provider’s response to the assessment team’s report received 26 March 2024. The response includes commentary and supporting documentation directly relating to deficits identified in the assessment team’s report, as well as a plan for continuous improvement outlining planned actions, planned completion dates and outcomes.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

**Standard 1 requirement (3)(b)**

* Ensure consumers are provided care in a culturally safe manner with their cultural preferences understood and respected.
* Ensure staff have the skills and knowledge to provide care and services to consumers in a way which ensures their cultural identity is recognised, valued and respected.
* Monitor staff interactions with consumers to ensure care and services are delivered in a culturally safe manner at all times.

**Standard 2 requirement (3)(b)**

* Ensure consumers’ goals, needs and preferences for care and services, including advance care and end of life are identified, documented and regularly reviewed in consultation with consumers and/or representatives.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 requirements (3)(a), (3)(b), (3)(d) and (3)(e)**

Ensure staff have the skills and knowledge to:

* Provide personal and or clinical/care and services to consumers in line with their assessed needs and preferences and that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation catheter care, personal care and behaviours;
* Identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks, including skin integrity/wounds, restrictive practices and choking;
* Use restrictive practices in line with legislative requirements, including ensuring appropriate consents and that they are used as a last resort;
* Recognise changes to consumers’ health and well-being, including weight loss, and implement appropriate monitoring and management strategies; and
* Ensure policies, procedures and guidelines in relation to best practice care, management of high impact or high prevalence clinical risks, and management of deterioration are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care, management of high impact or high prevalence clinical risks, and management of deterioration.

**Standard 4 requirements (3)(c) and (3)(f)**

* Ensure staff have the skills and knowledge to identify things of interest to each consumer, implement activity programs in line with consumers’ preferences, engage them in activities of interest, monitor consumers’ level of engagement and review effectiveness of each consumer’s participation in the program.
* Review the activity schedule in consultation with consumers and representatives to ensure it is reflective and appropriate. Monitor consumers’ satisfaction of the program on an ongoing basis and initiate changes in response to feedback.
* Monitor consumers’ satisfaction with meals and the dining experience on an ongoing basis and initiate changes in response to feedback.
* Review monitoring processes to ensure changes in consumers’ nutritional intake are identified, reported and documented to enable appropriate actions to be initiated.

**Standard 6 requirement (3)(c)**

* Ensure feedback and complaints are documented, including actions taken and follow-up with the complainant to ensure satisfaction is achieved.

**Standard 7 requirements (3)(b) and (3)(d)**

* Review staff practice monitoring processes and consider how consumer satisfaction with staff practices is captured, considered and actioned.
* Ensure staff are provided appropriate training to address the deficiencies identified in seven of the eight of the Quality Standards, and monitor staff practices to ensure they are in line with the service’s and organisation’s processes.

**Standard 8 requirement (3)(e)**

* Review the organisation’s clinical governance framework, specifically in relation to open disclosure and minimising use of restrictive practices.

# 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 | Not 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

The Quality Standard is non-compliant as one of six requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(b) in this Standard not met.

**Requirement (3)(b)** The assessment team found not all consumers are provided care and services that are culturally safe, or that each consumer’s cultural identity is considered and recommended this requirement not met. One consumer’s culture and how this may impact their needs or how they would like to receive care had not been understood until there was an escalation in behaviours impacting other consumers. Recommendations following review by specialist services in January 2024 include finding a service that can provide more culturally appropriate services, however, this has been delayed. Admission documentation does not identify the consumer’s cultural heritage and staff said they have not had any training relating to the consumer’s culture. Another consumer’s gender preferences for personal care have not been respected, with the consumer stating this occurs frequently and makes them uncomfortable. For another consumer, staff and management did not demonstrate an understanding their background and had not considered their past and present experiences.

The provider accepts the assessment team’s findings, acknowledging the service had not adequately identified one consumer’s cultural needs, considered the impact of a consumer’s background, and another consumer’s preferences were not documented. The plan for continuous improvement includes comprehensive, detailed actions to address the deficits identified by the assessment team at both individual consumer level and systems and process level, including, but not limited to, staff training and education, and reviewing and updating admission processes

I acknowledge the provider’s response. However, for the three consumers highlighted, the service has not ensured provision of culturally safe care and services or sufficiently identified and supported consumers’ cultural identity. This has resulted in perceived or real impacts for consumers, including increased behaviours, dissatisfaction with provision of care and services, and feeling uncomfortable during delivery of care. As such, I find the service has not ensured each consumer’s unique cultural identity is recognised, respected and supported or care and services are delivered in a culturally safe way. I acknowledge the actions planned to address the deficits identified outlined in the provider’s planned for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(b) in Standard 1 Consumer dignity and choice non-compliant.

**In relation to all other requirements**, each consumer is generally treated with dignity and respect and their identity, culture and diversity valued. Values of compassion and inclusion are included in job descriptions to ensure staff know they must uphold these values. Staff described how they respect consumers’ choices and maintain their dignity, and most consumers and representatives said interactions between consumers and staff are respectful and dignified.

Consumers are supported to exercise choice, including in relation to who is involved in their care and to maintain independence and connections with others. Consumers are asked on entry who they would like to be involved in their care and this is documented for reference. Consumers and representatives said consumers are given choice about when care is provided, and confirmed their choices are respected. Married couples are supported to maintain their relationships and are accommodated to share a room.

Consumers are supported to take risks that enable them to live their best lives. Where consumers are identified as undertaking an activity which includes an element of risk, assessments are completed, associated risks are discussed in partnership with consumers and/or representatives, and strategies to minimise risks are developed. Staff are aware of risks taken by consumers and said they support consumers’ wishes to take risks to live their life the way they choose.

Information provided to consumers is current, accurate and provided in a timely manner. Information is provided through various avenues, including newsletters, handbooks, meeting forums, menus and activity planners, enabling consumers to make informed choices about the care and services they receive and the way they are delivered. There are processes to ensure each consumer’s privacy is respected and personal information is kept confidential.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice compliant.

# 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. | Not 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

The Quality Standard is non-compliant as one of five requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(b) in this Standard not met.

**Requirement (3)(b)** The assessment team found information relating to consumers’ current needs, goals, and preferences, including advance care planning and culturally safe care, is not current and recommended this requirement not met. Discussions relating to end of life care are not undertaken until annual family case conferences once a consumer is settled into the service. The service is currently behind with these conferences, with 61 of 78 outstanding. Approximately 18 advance care directives are on record. Management said in the event of a consumer requiring end of life care and no directive, they would refer the consumer to hospital. One consumer wishes personal care to be undertaken by female care staff, and while they have repeatedly reported this, this information is not captured in the care plan. For another consumer, there is no information captured relating to spiritual and cultural care, with the entire section missing from the care plan. One consumer said they have preferences for particular staff which is not included in the care plan. The consumer’s care plan has not been reviewed since May 2023 despite the consumer having been hospitalised several times since.

The provider accepts the assessment team’s findings, acknowledging care provided to consumers highlighted does not meet their needs and expectations, and notes there is room for improvement in relation to advance care planning discussions with families. The plan for continuous improvement includes comprehensive, detailed actions to address the deficits identified by the assessment team at an individual consumer level and a systems and process level.

I acknowledge the provider’s response. However, this requirement expects that services do everything they reasonably can to plan care and services that centre on consumers’ goals, needs and preferences. I find this has not occurred for the consumers highlighted. Assessment processes have not identified consumers’ individual preferences for care and services. For one consumer, their cultural identity and related care and service needs have not been assessed or planned for, with the entire section relating to spiritual and cultural care missing from the care plan. Additionally, consumers’ preferences for advance and end of life planning have not been identified and planned for, with approximately 18 of 78 consumers’ advance care directives on record. Management indicate where consumers require end of life care and there is no advance care directive available, consumers would be referred to hospital, which may not be in line with consumers’ and/or representatives’ wishes, resulting in the consumer not having the end of life experience they may have wanted. As such, I find the evidence demonstrates care plans are not individualised and tailored to guide staff to provide care and services in line with each consumer’s needs and preferences or planned around what is important to them. I acknowledge the actions planned to address the deficits identified outlined in the provider’s planned for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to all other requirements**, there are effective assessment and planning process to ensure staff deliver safe and effective care and services. A range of assessments are undertaken and consultation with consumers and/or representatives occurs on entry and ongoing, with information gathered used to develop individualised support plans. Risks to consumers’ safety, health and well-being are identified and assessed through use of validated assessment tools, with strategies to reduce risk developed and documented.

Assessment and planning is inclusive of other organisations and providers of care, and staff described how allied health professionals and general practitioners contribute to the assessment of consumers’ care needs, with review outcomes incorporated into care plans to guide delivery of safe and effective care. However, two consumers had not been invited to be involved in assessment and planning processes for their end of life wishes and one representative did not recall being involved in assessment and planning.

Outcomes of assessment and planning are communicated to consumers and documented to guide staff to deliver care and services. Staff have access to care plans and assessments and where there are changes to the way consumers’ care and services are to be delivered, there are processes to ensure staff are informed. Consumers and representatives said they have received a copy of the care plan and are notified when changes to care occur. Care and services are reviewed regularly for effectiveness and in response to incidents or when consumers’ circumstances change. Resident of the day reviews are undertaken and include review of care plans, and referral to a general practitioner for a medication review. Annual family conference reviews for care planning involve consumers and representatives in evaluating if care and services meet consumers’ needs. The service is currently behind with annual reviews and a continuous improvement activity has been initiated to address this.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | Not 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. | Not 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 Quality Standard is non-compliant as four of seven requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(a), (3)(b), (3)(d) and (3)(e) in this Standard not met.

**Requirement (3)(a)** The assessment team found each consumer does not receive safe and effective personal or clinical care and recommended this requirement not met.One consumer had an incorrect size catheter inserted as staff could not find the correct size. Clinical, care staff and management gave different responses as to whether catheter output is recorded, and documentation for four consumers did not show output is consistently recorded. This is not in line with the organisation’s policy.A 30 minute sighting chart, implemented as a precaution for one consumer following statements of self-harm, was completed in full by staff at the end of the shift, and on the last day of the site audit, there were no entries on the chart when viewed at 2.11pm. Another consumer said male staff regularly attend their personal care which is against their wishes. One representative is concerned the service is not meeting another consumer’s care needs. Behaviour management supports have not been assessed, planned or reviewed on the consumer’s return from hospital in relation to refusal of care. Documentation did not evidence that if the consumer refuses one staff member to attend to care that an alternative staff member would be tried or that attempts have been made to accommodate and tailor staff to suit the consumer in order to ensure they receive the care they require.

The provider agrees with the assessment team’s findings. The plan for continuous improvement includes comprehensive, detailed actions to address the deficits identified by the assessment team, including consideration of actions to improve overall personal and clinical care systems and processes.

I acknowledge the provider’s response. However, I find consumers are not consistently provided safe, effective, best practice personal and/or clinical care that is tailored to their needs and optimises their health and well-being, including in relation to catheter care, personal care and behaviours. Staff described, and documentation sampled highlights inconsistent processes to manage and monitor catheter care requirements, which are not in line with the organisation’s policy and processes. Charting is not completed as intended, with a sight chart filled in by staff in full at the end of their shift, which does not ensure the consumer’s safety and well-being is appropriately and regularly monitored. Personal care is not consistently provided to a consumer in line with their preferences. I have also considered assessment and planning have not been undertaken to identify appropriate individualised strategies to manage and/or minimise a consumer’s behaviours which are impacting the provision of personal care.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)** The assessment team found processes to manage high impact or high prevalence risks are not effective and recommended this requirement not met. Timely wound care was not provided to prevent one consumer’s wound from becoming infected. Since return from hospital, a further wound infection has developed requiring antibiotics. Another consumer’s wound was identified as a friction wound and not a pressure injury, and there was no evidence to show the cause had been investigated. For another consumer, six months had not been considered as an excessively long time for a small skin tear to heal and had not been investigated or escalated for review. Four consumers have been administered psychotropic medications to treat behaviours in the past two months without documented informed consent. For one consumer, three staff said they had not displayed any of the behaviours that had been documented for the administration of an as required psychotropic medication on the second day of the site audit. Clinical staff said the consumer was ‘known’ to have the documented behaviours at times, and they were required to document behaviours in order to administer the medication, however, the consumer was required to attend an important specialist appointment which they had previously declined to attend, and it was important the consumer be compliant with their attendance. One consumer, who has a modified diet, is prescribed prophylactic antibiotics to prevent aspiration pneumonia, and needs to sit upright for meals. The consumer was not in an upright position before commencing meal assistance and was given the incorrect diet.

The provider agrees with the assessment team’s findings. The provider’s response includes additional information relating to wound management for one highlighted consumer identified with an infection, including actions and improvements implemented as a result of internal investigations. The plan for continuous improvement also includes comprehensive, detailed actions to address the deficits identified by the assessment team, including, but not limited to, staff education and training, review of behaviour support plans, and enhanced monitoring processes.

I acknowledge the provider’s response. However, this requirement expects that services effectively manage high impact or high prevalence risks associated with the care of each consumer. That is, each individual consumer should expect to have high impact or high prevalence risks associated with their care effectively managed. I find this did not occur in relation to risks associated skin integrity/wounds, restrictive practices and choking. Wounds are not being correctly classified, cause investigated or referrals to investigate and review initiated, including in relation to delayed healing. Restrictive practices, specifically use of psychotropic medications, have not been used in line with legislative requirements or as a last resort. Four consumers administered psychotropic medications to manage behaviours do not have the required consents. For one consumer, behaviours which were not displayed were documented to support the use of a psychotropic medication which was administered as the consumer was required to attend an appointment they had previously declined. For another consumer strategies to mitigate risks of choking and aspiration were not implemented prior to staff commencing meal assistance, placing the consumer at risk.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(d)** The assessment team found changes in consumers’ condition, capacity or function is not recognised or appropriately responded to and recommended this requirement not met.Increased monitoring of blood glucose levels, in line with policy, was not undertaken when one consumer was unwell and deteriorating. One consumer’s deterioration was not recognised or responded to and the representative expressed concerns that the consumer’s mental health is deteriorating, impacting on them eating and drinking. Staff are not documenting when consumers are not eating their meals or escalating this to clinical staff. Monthly weights are not actioned when weight loss is identified and instead are left until all weights for an area have been completed until review. One consumer, identified at risk of malnutrition, recorded weight loss which was not recognised or responded to in a timely manner. Staff stated the consumer does not eat lunch most days, however, this has not been documented.

The provider accepts the assessment team’s findings. The plan for continuous improvement includes comprehensive, detailed actions to address the deficits identified by the assessment team, including, but not limited to, staff education and training; implementing a process to identify and mage consumers with high impact or high prevalence clinical risks; and enhancing monitoring of consumers with or at risk of significant weight loss.

I acknowledge the provider’s response. However, I find for consumers highlighted, changes or deterioration in condition are not recognised or responded to promptly. Where there have been changes in condition, additional monitoring has not been implemented in line with organisational policy. Prompt review of weights is not undertaken to enable timely actions to occur in response to identified weight loss, which is further compounded by staff not reporting or documenting changes in consumers’ nutritional intake.

For the reasons detailed above, I find requirement (3)(d) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(e)** The assessment team found effective and consistent processes are not in place to record timely and accurate information relating to consumers’ conditions, needs and preferences and recommended this requirement not met. Staff provided varying responses on where, how and when to document information regarding consumers’ care needs, and consumers reported having to repeat information regarding safe care practices. Catheter care charting for four consumers was not completed or partially completed in charts and/or progress notes. Staff provided varying responses as to how to document repositioning for consumers requiring pressure area care and charts sampled were partially completed. Some staff stated they would document position changes and times in progress notes and others stated always in a chart. Observations for a consumer had been completed on multiple occasions over an eight day period in August 2023, however, the consumer was in hospital during this period and not residing at the service.

The provider partially accepts the assessment team’s findings, stating the organisation has processes to record timely and accurate information relating to consumers’ conditions, needs and preferences. The plan for continuous improvement includes actions to address the deficits identified by the assessment team, including, but not limited to, staff education and training.

I acknowledge the provider’s response. However, I find information about consumers’ condition, needs and preferences is not effectively or consistently documented and communicated. Consumers described having to repeat information to staff relating to safe care practices, and staff described, and documentation showed inconsistent documentation and reporting practices relating to consumer information, such as catheter output, nutritional intake and pressure area care. As such, I find current practices do not ensure effective oversight and monitoring of changes to consumers’ condition, needs and preferences.

For the reasons detailed above, I find requirement (3)(e) in Standard 3 Personal care and clinical care non-compliant.

**In relation to requirements (3)(a), (3)(b), (3)(d) and (3)(e)**, I acknowledge actions planned to address the deficits identified outlined in the provider’s plan for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to these requirements.

**In relation to requirements (3)(c), (3)(f) and (3)(g)**, consumers said they have access to external providers to meet their care needs. Care files demonstrate timely referrals to general practitioners and/or allied health professionals are initiated and recommendations incorporated into care plans. Specialised services, general practitioners and family are engaged for consumers’ end of life care and comfort, and clinical staff said they refer to consumers’ advance care directives for end of life goals and preferences to ensure their dignity is preserved. One consumer’s care file included an advance care directive stipulating family would provide comfort care in the form of music and aromatherapy. Progress notes show the family was informed of the consumer’s deteriorating condition and were present with the consumer when they passed away.

Infection related risks are minimised through implementation of standard and transmission-based precautions to prevent and control infections. Staff described how they can prevent infections and transmission, including through good hygiene practices and use of personal protective equipment. Specimens are collected for pathology to ensure appropriate antibiotic prescribing and infection forms are completed for where infections are identified. Overall, antimicrobials have been prescribed for a short duration and where there are symptoms or infection. The service has an infection prevention and control lead and an infection control champion who monitor staff practice through observation and audits to identify areas for improvement.

Based on the assessment team’s report, I find requirements (3)(c), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# 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. | Not 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. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is non-compliant as two of seven requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(c) and (3)(f) in this Standard not met.

**Requirement (3)(c)** The assessment team found services and supports for daily living do not assist each consumer to do the things of interest to them or have social relationships of meaning and recommended this requirement not met. Four consumers said they choose not to take part in social group activities as they do not find them stimulating and/or meaningful. Comments included they do not participate in social group activities as consumers of all abilities are grouped together; they have not made many friends as the service does not promote a sense of connection through social group activities with other like-minded consumers; and they feel lonely as other consumers participating in activities are less cognitively able compared to them. One consumer was secluded from group activities or not engaging with the lifestyle program due to their behaviours. The service was unable to describe what strategies, if any, had been considered for this consumer to increase opportunities for social participation. Monthly activity surveys are not completed and consumers’ satisfaction with lifestyle activities is evaluated once per year. The last survey completed in July 2023 showed 17% of consumers either never or some of the time have a say in their daily activities.

The provider partially accepts the assessment team’s findings stating while the service provides a varied range of activities, it is acknowledged the program of activities is not meeting the needs and preferences of all consumers. The plan for continuous improvement includes actions to address the deficits identified by the assessment team, including, but not limited to, review of the activities program and consideration of consumers’ culture and diversity when programming activities.

I acknowledge the provider’s response. However, I find services and supports do not assist each consumer to participate in the service’s community, have social relationships or do things that are of interest to them. In coming to my finding, I have placed weight on feedback provided by consumers indicating they do not find social group activities stimulating and/or meaningful and the impacts, including on their well-being described, as well as observations of another consumer who was socially isolated due to their behaviours. I have also considered the service has not effectively used their own monitoring processes to gauge consumer satisfaction with the activities provided. As such, I find the service has not ensured services and supports, specifically the lifestyle program, have been tailored to meet the unique needs of consumers or to provide them with a sense of purpose and identity.

For the reasons detailed above, I find requirement (3)(c) in Standard 4 Services and supports for daily living non-compliant.

**Requirement (3)(f)** The assessment team found meals provided are not varied or of suitable quality and quantity. Four consumers said they do not like food and do not always eat their meals, and staff are not consistently documenting consumers’ meal refusal/poor appetite. Consumers have made complaints to staff about the quality of the food and their dislike of meals, however, issues are ongoing as complaints are not always escalated or reported. One consumer was provided a meal that was not in line with their dietary needs, and staff assisting consumers on modified diets were often not aware of the meal they were providing consumers so would not be able to inform the consumers what they were eating. Results of a customer experience survey conducted in July 2023 showed one third of consumers were unhappy with the meals which has resulted in the implementation of a number of improvements. However, management also acknowledged formal feedback from consumers and representatives has not been sought as to whether these changes have made a difference in the overall dining experience.

The provider partially accepts the assessment team’s findings. The response states the organisation-wide mealtime experience project to improve meal choices and dining experience was commenced in response to consumer feedback. The project is still progressing and improvements have been noted. The provider also accepts a staff member did not follow procedure and provided a consumer with a meal which was not in line with the documented texture. The plan for continuous improvement includes actions to address the deficits identified by the assessment team, including, but not limited to, staff education and training, commencement of a site-based food focus group, and enhanced monitoring of mealtimes.

I acknowledge the provider’s response. However, I find meals provided are not of suitable quality or variety. In coming to my finding, I have placed weight on feedback provided by consumers, as well as observations of consumers not eating meals and being provided meals not in line with their dietary requirements. I have also considered the services’ processes to monitor consumers’ nutritional and hydration intake are not effectively implemented as poor oral intake or refusal of meals is not being reported or documented. I also find for consumers on modified textured diets, there is a potential for the dining experience to be compromised with staff not aware of the meals they are providing to inform consumers prior to assisting them.

For the reasons detailed above, I find requirement (3)(f) in Standard 4 Services and supports for daily living non-compliant.

**In relation to requirements (3)(c) and (3)(f)**, I acknowledge the actions planned to address the deficits identified outlined in the provider’s plan for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to these requirements.

**In relation to all other requirements,** consumers were found to receive safe and effective supports for daily living which meet their needs and optimise their independence, health, well-being, and quality of life. Care plans reflect consumers’ goals, needs, preferences for daily living and required supports. Therapy staff complete assessments with consumers and their families on entry and then review them annually or where changes occur. Appropriate equipment, based on assessed needs, is provided to consumers to enable independence and therapy programs are implemented which are tailored to consumers’ individual needs, goals, and preferences. Consumers said they have been supported with the provision of mobility and adaptive equipment and exercises which helps them optimise their independence and well-being.

Services and supports for daily living promote each consumer’s emotional, spiritual, and psychological well-being. Weekly church services are offered and referrals to a chaplain are initiated, where required. Occupational therapy assistants spend one-on-one time with consumers experiencing low mood, however, this is not documented. Staff said they report any consumers that are not socially engaged, seem in a low mood, or have decreased attendance at lifestyle activities to clinical and therapy teams for further evaluation, with referrals to external psychology services initiated, if required.

Information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely referrals are initiated. Clinical and therapy teams have regular multidisciplinary meetings where they can refer consumers for review where changes or deterioration in health or well-being have been identified. Care staff described how they are kept up to date with consumers’ changing needs and preferences, and consumers and representatives said consumers do not have to repeat information to staff about their needs and preferences for care and services.

Equipment provided is safe, suitable, clean and well-maintained. All new equipment is closely monitored to ensure safety, comfort, and suitability. Consumers feel safe when using equipment and said equipment is easily accessible and suitable for their needs. Consumers feel comfortable to raise any concerns if equipment needs repair and are aware of processes for reporting issues.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g) in Standard 4 Services and supports for daily living compliant.

# Standard 5

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

Findings

Consumers and representatives said the environment is welcoming, consumers like living at the service and they can personalise their rooms. Each area of the service is clean, with suitable and home like furnishings, signed pathways and corridors and handrails. Each area has communal lounge and dining areas, and external gardens and courtyards for consumers and visitors to meet.

The service environment is clean, comfortable, and well maintained and furniture, fittings and equipment are safe, clean and well maintained. Cleaning is undertaken in line with a set task list, and reactive and preventative maintenance processes are in place. Emergency evacuation diagrams are displayed throughout the service and fire equipment checks are up to date. Consumers can move freely within the service both indoors and outdoors, with doors to garden and courtyard areas unlocked enabling easy movement. Consumers and representatives are satisfied with the standard of cleanliness of consumer rooms and said common areas are comfortable and they feel safe in the service environment. Consumers and representatives also said equipment is suitable for consumers’ care needs and is safe for use.

Based on the assessment team’s report, I find all requirements in Standard 5 Organisation’s service environment compliant.

# 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Quality Standard is non-compliant as one of four requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(c) in this Standard not met.

**Requirement (3)(c)** The assessment team found appropriate action is not taken by staff in response to feedback. Only two complaints were provided to the assessment team to review, with one still in the process of being actioned. While several consumers reported not enjoying or not eating meals, there was no related feedback recorded in the feedback register to demonstrate feedback had been actioned and responded to. An open disclosure approach in response to incidents was not demonstrated.

The provider partially accepts the assessment team’s findings. The provider’s response indicates a review of 13 complaints from September 2023 to February 2024 had been followed up, the outcome from the complainant sought, and resolution to the complainant’s satisfaction documented. The provider’s response also included supporting documentation to demonstrate actions taken in response to feedback/incidents relating to a representative and consumer. The plan for continuous improvement includes actions to address the deficits identified by the assessment team, including, staff education and training.

I acknowledge the provider’s response. However, I find a best practice system for managing and responding to complaints was not demonstrated, including use of open disclosure. I acknowledge the provider’s response stating a review of complaints for a four month period undertaken subsequent to the site audit demonstrated appropriate actions have been taken in response. However, in coming to my finding, I have placed weight on the fact that only two complaints were provided to the assessment team to review, with one complaint still in the process of being actioned. This is not sufficient to demonstrate appropriate action is taken in response to complaints or an open disclosure approach is consistently used. I have also considered that while a number of consumers raised concerns relating to meal satisfaction, there was no related feedback recorded on the feedback register. I acknowledge the actions planned to address the deficits identified outlined in the provider’s plan for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(c) in Standard 6 Feedback and complaints non-compliant.

**In relation to requirements (3)(a), (3)(b) and (3)(d)**, consumers and representatives said they feel encouraged and supported to provide feedback and make complaints, and feel comfortable speaking directly to management to raise concerns. A welcome pack and customer feedback policy and procedure provides information relating to internal and external complaints avenues and advocacy services, and information about advocates, language services and other methods for raising complaints is displayed throughout the service, accessible to consumers, visitors and staff. Feedback is also encouraged through regular consumer and representative meeting forums and annual surveys. Feedback and complaints forms and boxes are located around the service, however, some boxes are not clearly marked and forms were not located in all areas. While most consumers and staff are not aware of other services available to raise and resolve complaints, they feel the service responds to their feedback and complaints appropriately.

Consumers and representatives interviewed are satisfied their feedback is used to improve care and services. Feedback and complaints data is analysed on a regular basis and is used to identify improvement opportunities.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b) and (3)(d) in Standard 6 Feedback and complaints compliant.

# 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. | Not 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Quality Standard is non-compliant as two of five requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(b) and (3)(d) in this Standard not met.

**Requirement (3)(b)** The assessment team found workforce interactions, specifically night staff, with consumers are not kind, caring and respectful and recommended this requirement not met. Two consumers made allegations that night staff do not treat them with respect and kindness, describing incidents of rough handling, or staff not assisting them when requested, and two consumers reported incidents of staff not being kind or respectful to them.

The provider accepts the assessment team’s findings and states management have followed up with the consumers who raised concerns and an investigation is in progress to identify the staff members and to take appropriate action.

I acknowledge the provider’s response. However, I find workforce interactions, specifically those of night staff, are not kind, caring and respectful. I have placed weight on feedback provided consumers and the descriptions they provided relating to how staff behaviours make them feel. Comments included feeling like they are being kept in a prison, staff not acknowledging how they are feeling and their requests being questioned. I find such interactions described have the potential to impact the outcomes of consumers’ care and services, including their safety, health and well-being.

For the reasons detailed above, I find requirement (3)(b) in Standard 7 Human resources non-compliant.

**Requirement (3)(d)** The assessment team found the workforce does not have the knowledge to deliver safe care and services and recommended this requirement not met. The service had previously identified gaps in staff knowledge, including in relation to management of wounds and urinary catheters and provided training and instructed staff to review policies, however, effectiveness of training has not been evaluated. While staff have been provided training on restrictive practices, knowledge deficits related to what a chemical restraint is and seclusion have been identified. Training on how to conduct an incident investigation has not been provided resulting in prevention strategies not being consistently documented or not addressing the issue. Management did not appear to be aware of when incidents met Serious Incident Response Scheme (SIRS) reporting requirements. The service is behind in the mandatory training program

The provider accepts the assessment team’s findings, stating areas for improvement relating to wound management and pressure injury prevention had been identified by internal audit processes, and actions were in place to address these areas. The plan for continuous improvement includes actions to address the deficits identified by the assessment team, including, but not limited to, staff education and training, and assessment of staff knowledge gaps and performance appraisals.

I acknowledge the provider’s response. However, I find processes to ensure the workforce is trained, equipped and supported to deliver the outcomes required by these Standards was not adequately demonstrated. While deficits in staff knowledge relating to management of wounds and catheters have been identified by the service, actions implemented to address these deficits have not been effective, and training provided to staff relating to restrictive practices has also not been effective. Staff practices relating to these areas has not been effectively monitored with deficits relating to management of wounds, catheters and restrictive practices identified and related requirements found non-compliant.

For the reasons detailed above, I find requirement (3)(d) in Standard 7 Human resources non-compliant.

**In relation to requirements (3)(b) and (3)(d)**, I acknowledge the actions planned to address the deficits identified outlined in the provider’s plan for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to these requirements.

**In relation to requirements (3)(a), (3)(c), and (3)(e),** management described processes to ensure the workforce is planned and the number and mix of staff deployed enables delivery of quality care and services, including processes for planned and unplanned leave. Staff from various disciplines are satisfied there are enough staff available to meet consumers’ needs and they have enough time to do their job. Consumers and representatives are satisfied with the mix and level of staff, stating staff attend consumers promptly and they do not have to wait for assistance.

Consumers and representatives are satisfied with the care consumers receive and have confidence in the workforce to effectively perform their role. Position descriptions outline minimum qualification requirements and duty statements to guide staff in their roles. Staff competency is monitored through direct observation and feedback from consumers, representatives, and staff, and there are processes to monitor professional registrations and police clearances. Staff from various disciplines said they have completed mandatory training and feel supported by management.

There are processes to regularly assess, monitor and review staff performance. All new and existing staff members complete formal performance appraisals where they can discuss their roles and identify training needs and goals, and there are processes to manage poor performance. Consumers and representatives are satisfied with the performance of staff, feel comfortable to provide feedback to management regarding staff performance and are confident action is taken in response to poor performance.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c) and (3)(e) in Standard 7 Human resources 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. | 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. | Not Compliant |

Findings

The Quality Standard is non-compliant as one of five requirements assessed has been found non-compliant. The assessment team recommended requirements (3)(a), (3)(d) and (3)(e) in this Standard not met.

**Requirement (3)(a)** While the organisation has systems and processes to seek feedback and engage consumers in the development, delivery and evaluation of care and services, the assessment team found consumers at St Georges Care Centre have not engaged in the process and recommended this requirement not met. While regular resident and representative meetings occur, minutes do not evidence feedback has been able to be actioned. Several consumers said activities are not of interest to them, and while management state feedback about activities is gathered through monthly audits, this has not happened and evidence of this was not provided. There is no evidence to demonstrate consumer input into the design of the activity program. Family conferences to involve consumers and representatives in evaluating how care and services are delivered are behind, and there are no recorded improvements to demonstrate how conferences are used to improve the service.

The provider partially accepts the assessment team’s findings. The response states feedback is welcomed and encouraged, and outlines a range of mechanisms available to consumers to provide feedback.

I have come to a different finding to that of the assessment team. In coming to my finding, I have considered evidence presented in the assessment team’s report across the Quality Standards demonstrating there are processes to engage and support consumers in the development, delivery and evaluation of care and services. Consumers described involvement in development of care and services, including through care plan meetings and surveys. In response to consumer feedback, an organisation-wide mealtime experience project has been implemented to improve meal choices and dining experience, and while feedback relating to this project has not been sought, the provider’s response includes a number of improvements which have resulted from this project to date and indicates the project is still progressing. Consumers and representatives also stated their feedback is used to improve care and services. I acknowledge consumer feedback relating to dissatisfaction with meals and the activities program, however, I have considered this feedback in my finding for related requirements in Standard 4 which has been found non-compliant.

For the reasons detailed above, I find requirement (3)(a) in Standard Organisational governance compliant.

**Requirement (3)(d)** The assessment team found risk management systems are not effective in identifying cause and preventing reoccurrence of harm to consumers and recommended this requirement not met. The incident management system did not evidence investigations are completed to determine or identify cause and/or ways to prevent re occurrence. Investigations do not evidence consideration of if consumers are safe from harm, including potential abuse or unreasonable use of force. Two consumers have been found with unexplained bruising or injuries on more than one occasion where a thorough investigation to identify the cause was not completed. For one consumer, an injury sustained had not been considered a reportable incident as the service was not sure of the cause. Two consumers said they had told night staff they were being rough during personal care, however, there are no related incident reports.

I have come to a different finding to that of the assessment team. I find the evidence presented does not demonstrate systemic issues relating to risk management systems and practices. In coming to my finding, I have placed weight on supporting documentation included in the provider’s response. For one consumer highlighted, supporting documentation demonstrates incident reports were completed for two of the three skin integrity incidents and appropriate actions, including assessment, additional monitoring, notification to the general practitioner and next of kin and review of CCTV footage were initiated in response. For another consumer with unexplained bruising, a clinical investigation was conducted by an independent team which considered contributing factors and outlined a range of recommendations. While I acknowledge feedback from two consumers describing rough handling by night staff, there is no indication these instances were reported or escalated to the management team to enable investigations to be initiated. The provider’s response indicates an investigation has been commenced to identify the staff members involved.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance compliant.

**Requirement (3)(e)** The assessment team found the clinical governance framework was not effective in ensuring processes and policies are adhered to or antimicrobial stewardship, minimising use of restraint and use of open disclosure is monitored and recommended this requirement not met. While a policy is in place, regular monitoring of antimicrobial use was not demonstrated. The policy states consumers on long term antibiotic therapy need this reviewed every six to 12 months, however, a process to ensure this occurs was not demonstrated. The audit calendar only includes an antimicrobial stewardship once a year and there is no clear allocation of the task to review that all antibiotics prescribed have a start and end date. Staff involved in monitoring of antimicrobial stewardship did not demonstrate an in depth knowledge of how this occurs.

A policy guides staff on how to use open disclosure and includes the components of open disclosure and tick boxes for staff to check they have completed it. While staff have a general understanding of open disclosure, not all staff understand and provide all components of this process when incidents occur. Governance systems are not effective in ensuring consumers who receive psychotropic medications to modify behaviours are identified as having chemical restraint and have not identified staff are practicing seclusion in relation to one consumer. The service has identified two consumers as having chemical restrictive practices, however, the assessment team identified a further four consumers who are receiving psychotropic medications to modify their behaviours. The psychotropic register is reviewed three monthly, however, only consumers’ diagnosis is considered and not why medications are administered, including to modify consumers’ behaviours.

The provider partially accepts the assessment team’s findings. The provider’s response includes an overview of the organisation’s clinical governance framework which is supported through policies and procedures, audit programs, incidents and complaints management systems and performance monitoring. The plan for continuous improvement includes actions to address the deficits identified by the assessment team, including, but not limited to, staff education and training, and weekly review of psychotropic medications.

I acknowledge the provider’s response. However, I find the organisation’s clinical governance framework, specifically in relating to open disclosure and minimising use of restraint, is not effective. Not all staff understand open disclosure and documentation sampled demonstrates open disclosure processes, in line with policy, are not consistently completed. I have also considered as highlighted in requirement (3)(c) of Standard 6, information provided to the assessment team to demonstrate actioning of complaints, including use of open disclosure principles was limited. Not all consumers subject to restrictive practices have been identified, and psychotropic medications have not consistently been used in line with legislative requirements or as a last resort. While there are processes to review the psychotropic register, reviews do not consider why medications are administered which may assist the service to identify opportunities to minimise use of restrictive practices. I acknowledge the actions planned to address the deficits identified outlined in the provider’s plan for continuous improvement. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-compliant.

**In relation to requirements (3)(b) and (3)(c),** the organisation’s core values, priorities and strategic directions are promoted and communicated throughout the service. The organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. The governing body monitors performance indicators, such as incidents, complaints and clinical indicators and benchmarks these against other services. Monthly performance level information is captured and analysed to identify trends, with resulting actions for improvement implemented and clearly communicated.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance and feedback and complaints. There are processes to ensure these areas are monitored and the governing body is aware of and accountable for the delivery of services.

Based on the assessment team’s report, I find requirements (3)(b) and (3)(c) in Standard 8 Organisational governance compliant.

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