Performance

Report

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| Name: | TriCare Ashgrove Aged Care Residence |
| Commission ID: | 8247 |
| Address: | 31 Nathan Avenue, Ashgrove, Queensland, 4060 |
| Activity type: | Site Audit |
| Activity date: | 26 June 2024 to 28 June 2024 |
| Performance report date: | 14 August 2024 |
| Service included in this assessment: | Provider: 7125 Tricare Ashgrove Aged Care Pty Ltd  Service: 26584 TriCare Ashgrove Aged Care Residence |

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 TriCare Ashgrove Aged Care Residence (**the service**) has been prepared by Katherine Richards, 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, management, and others; and
* the provider’s response to the assessment team’s report received 31 July 2024.

# 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 | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not 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.

* **Requirement 1(3)(d):** The provider ensures all consumers are aware and supported to take risks of choice in line with policies and procedures.
* **Requirement 2(3)(a):** The provider ensures assessment and planning, including consideration of risks relating to application of restrictive practices, complete diagnoses are known and used within assessment and planning processes and used to inform care and services delivered
* **Requirement 2(3)(b):** The provider ensures assessment and planning considers and captures current needs, goals, and preferences of consumers, particularly in relation to wound care, pain management, and personal care preferences. Palliative and end of life care planning is to be undertaken in line with organisational policies and procedures.
* **Requirement 2(3)(e):** The provider ensures processes to review the effectiveness of care and services are understood and practiced in line with policies and procedures, especially following incidents or deterioration of consumer condition.
* **Requirement 3(3)(a):** The provider ensures consumers receive clinical and personal care that is best practice and tailored to their needs to optimise health and wellbeing, particularly in relation to wound care and application of restrictive practices.
* **Requirement 3(3)(b):** The provider ensures high impact and high prevalence risks associated with the care of consumers are identified and effectively monitored and managed in line with directives, including in relation to falls, pain, diabetes, and urinary catheter care. Processes and practices are available to support staff awareness of risks and management strategies.
* **Requirement 3(3)(e):** The provider ensures information about consumers’ condition, needs, and preferences is clearly and accurately reflected within documentation and handover practices to communicate with staff, including new and temporary staff, and others involved in provision of care.
* **Requirement 3(3)(f):** The provider ensures staff are aware of available services, supports, and pathways to ensure timely and appropriate referrals are made to meet consumer needs.
* **Requirement 5(3)(b):** The provider ensures the service environment and security measures enable consumers to move freely through indoor and outdoor areas, where it is safe to do so.
* **Requirement 6(3)(d):** The provider ensures complaints and feedback are documented, opportunities for improvement identified and improvement actions implemented. Continuous improvement activities are to be implemented within a timely manner, with review and evaluation of progress.
* **Requirement 7(3)(a):** The provider ensures the number and mix of staff deployed enables the delivery and management of safe and quality care and services, particularly in relation to clinical care and a growing consumer cohort.
* **Requirement 7(3)(d):** The provider ensures all staff, including new and temporary staff, have sufficient training and support to deliver safe and quality care in line with expectations within the Quality Standards.
* **Requirement 7(3)(e):** The provider ensures the workforce performance is assessed, monitored, and reviewed in accordance with its own policies and procedures. The service will ensure it can demonstrate there is monitoring for completion of formal assessments and timely action taken in response to under performance.
* **Requirement 8(3)(c):** The organisation ensures deficits in systems relating to information management, workforce governance, regulatory compliance, feedback and complaints and continuous improvement are remedied to ensure effective governance and oversight.
* **Requirement 8(3)(d):** The provider ensures the risk management systems and practices effectively support staff in the provision of consumer care, with monitoring and oversight to identify deficiencies and drive improvements.

# 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. | Not 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

This Quality Standard is Not Compliant, as one of the 6 Requirements has been assessed Not Compliant.

The assessment team recommended Requirement 1(3)(d) Not Met, as consumers had not been supported to take risks. Staff were aware of requirements and processes to support consumers take risks, however, could not provide relevant examples or assessments for consumers. A consumer said their request for a risk of choice was denied, despite having a safety assessment undertaken prior to entry, and explained the available alternates options included risks that had not been considered on an individual basis. An organisational dignity of risk policy included guidance on positive risk taking to support consumers live the best life, outlining responsibility for risk assessment and consultation and ensuring compliance with the policy, however, the service could not demonstrate this was practiced.

The provider’s response includes actions taken for the named consumer reporting concerns, with assessment and consultation. Supporting documents included a copy of the assessment and evidence of this being incorporated into the care and services plan.

I acknowledge the provider’s response and actions taken for the named consumer. However, I find no evidence within the response or Plan for Continuous Improvement (PCI) actions that supports changes in practice to improve staff awareness and prevent recurrence, or to determine if there were other impacted consumers. Accordingly, I find Requirement 1(3)(d) Not Compliant.

I am satisfied the other Requirements in Standard 1 Consumer dignity and choice are Compliant.

Overall, consumers and representatives described consumers being treated with dignity and respect, with staff respectful of their culture, identity, and diversity. One consumer described how delays in waiting for care impacted their dignity and well-being and isolated them from scheduled activities, with management acknowledging the impact of delays and committing to improvements. Staff knowledge of consumer life stories, cultural backgrounds, and preferences exceeded information within care planning documentation, and informed care and interactions. Policies, procedures, and training supported staff in practices in understanding consumer diversity and identity and ensuring they were treated with dignity and respect.

Consumers explained staff took time to understand their cultural needs, which were outlined through assessment and planning processes. Care planning documentation was not always consistent with consumer needs for cultural safety, and a consumer said there were occasions where staff were not aware of their preference for staff of the same gender for hygiene care. Management made necessary changes to care planning documentation in response to feedback. Overall, staff demonstrated awareness of cultural needs for consumers, stating they learned through day to day interactions, and had education on provision of culturally safe care.

Staff provided examples of how they supported consumers to make choices about care and service delivery and who should be involved in their care, with relationships encouraged and supported through offering privacy where preferred. Consumers and representatives verified consumers were supported to make decisions about care and relationships were respected. Care planning documentation reflected who was involved in decision-making for consumers, and consumers were informed of options to choose who was involved in their care within the consumer handbook.

Consumers said they received sufficient timely information to support decision making and choices. Staff explained how information was provided in writing, such as through meeting minutes, newsletters, emails, posters, and calendars, and documentation for consumers was observed to be clear with suitable size and format to support understanding. Electronic menus were displayed in the dining room, and consumers were verbally asked for preferred choice of meals.

Consumers offered examples of how staff respected their privacy, such as knocking and seeking permission before entering rooms. Staff said they can also place ‘do not disturb’ signs if consumers choose this, and ensured information was kept confidential in secured computers and through ensuring discussions were in private.

# 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. | Not 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. | Not Compliant |

Findings

This Quality Standard is Not Compliant, as 3 of the 5 Requirements have been assessed as Not Compliant.

The assessment team recommended Requirements 2(3)(a), 2(3)(b) and 2(3)(e) Not Met.

Requirement 2(3)(a)

Whilst staff could describe assessment processes used to identify consumer needs and inform care, the assessment team found assessment and planning did not demonstrate consistent understanding and assessment in relation to restrictive practices. Consumers prescribed medications used as chemical restraint did not always have effective risk assessment with required consent or behaviour support plans, despite staff demonstrating awareness of legislative requirements. Behaviour support plans for consumers subject to environmental restraint were generic, and restrictions to free movement, managed through coding within consumer fob access levels, had not been identified as potential environmental restraint.

Records of diagnoses were incomplete for one consumer and the service was unable to demonstrate they followed documented communication processes to effectively share all information about new consumers. This resulted in lack of staff awareness and impacted assessment and planning processes to identify consumer risks and inform care.

Management acknowledged findings during the Site Audit, and the provider’s response includes investigation and clarification of circumstances of named consumers with actions taken. Investigations identified other consumers who may have been impacted with appropriate actions also undertaken. Training has been coordinated for clinical staff to refresh understanding of restrictive practices. Reports were made to the Serious Incident Response Scheme (SIRS) in relation to identified unauthorised use of restrictive practices. In relation to the named consumer with incomplete diagnoses documentation, a review of assessment, planning and care delivery was undertaken, without requirement for change in care and verifying the consumer’s care had not been compromised. A review of environmental restraint assessment and practices has resulted in a reduction in the number of consumers on the restrictive practice register, and those not subject to environmental restraint have a working key fob to support access through the front door.

I acknowledge the provider’s response and actions. Whilst the provider’s response overall demonstrates understanding of deficiencies, it will take time to demonstrate the effectiveness of improvements, including staff education, on assessment and planning practices. This is reflected within the Plan for continuous improvement, as developed activities are ongoing without scheduled date for completion. In coming to my decision, I have also placed weight on findings in other Standards relating to the number of new staff and periodical dependence upon agency staff, who rely upon clear assessment and planning outcomes to inform safe and effective consumer care. Accordingly, I find Requirement 2(3)(a) Not Compliant.

Requirement 2(3)(b)

The assessment team found assessment and planning did not reflect current needs, goals, and preferences of consumers in relation to dietary needs and preferences, wound management, pain management, and personal care preferences. Whilst staff described how they used assessment and planning to identify consumer needs and preferences, feedback from consumers and representatives did not always align with care planning documentation. Clinical staff were unaware of specialist directives to provide pain management prior to attending a consumer’s wound care, and stated the recommended wound care products were not always stocked. Consumers with preferences for gender of care staff for personal care said this was not always recognised, with staff advising consumer preferences were known by regular staff however this was not reflected within care planning documentation. A consumer who had entered the service for provision of palliative care did not have any record of palliative care goals or preferences, despite having had care conference assessments undertaken.

Management acknowledged findings during the Site Audit, and the provider’s response includes investigation and clarification of circumstances of named consumers. In relation to the consumer reporting their dietary needs were not understood, the provider has demonstrated misunderstandings of the food intolerance, and documentation effectively captured needs and preferences. Deficiencies in the provision of wound care were identified prior to the Site Audit, with improvements already being implemented for all consumers with active wounds, and a SIRS report lodged in relation to the deficiencies in wound care for the named consumer. Wound charts were being updated to ensure they were reflective of directives and policies. Education had been provided to staff on documentation and policy for wound care, with increased monitoring for adherence. Staff are now required to document when pain relief is offered and declined. Care planning documentation has been updated for the named consumer in relation to personal care preferences, with an alert on their file to ensure awareness. The provider has not addressed the omission of palliative care goals or preferences but acknowledged documentation errors within diagnoses.

I acknowledge the provider’s response and actions undertaken. I am satisfied there was misunderstanding in relation to the communications about dietary needs and preferences for the consumer. However, I find deficiencies within assessment and planning contributed to poor care and outcomes for consumers, particularly relating to wound care, and this is reflected further within findings of non-compliance relating to the delivery of clinical care outlined in Standard 3. Improvements in assessment and planning practices will take time to embed into practice. Accordingly, I find Requirement 2(3)(b) Not Compliant.

Requirement 2(3)(e)

Care planning documentation did not reflect consistent processes in reviewing the effectiveness of care and services following incidents or deterioration, particularly following falls and wound deterioration or infection. Staff stated the electronic care management system has embedded prompts for completion, however, believed new or agency staff were not always aware of the process. Management attributed deficiencies due to poor clinical oversight.

The provider’s response acknowledges deficits with commitment to improvement and to learn from these matters. They believe deficiencies stemmed from instability in onsite management, resulting in non-adherence of policies and processes. Actions taken include, but are not limited to, providing reminders and refresher education for all clinical staff, reviewing the Falls prevention and management policy, improving documentation practices, and auditing for effectiveness.

I acknowledge the provider’s response and actions being undertaken. In coming to a decision of non-compliance I have considered the impact of deficiencies in evaluating the effectiveness of care and findings on consumer health and well-being, outlined in findings in Standard 3. The provider’s improvement actions in the Plan for continuous improvement are combined for Requirements 2(3)(a), 2(3)(b), and 2(3)(e), and although they do include increased organisational monitoring of assessment and planning for new consumers, I am not satisfied they effectively address deficiencies relating to evaluation of effectiveness of care for all consumers. Accordingly, I find Requirement 2(3)(e) Not Compliant.

I have found Requirements 2(3)(c) and 2(3)(d) Compliant.

Overall, consumers and representatives described engaging with staff for assessment and planning processes and were aware of other involved providers. One consumer stated they hadn’t spoken with staff in any meetings, however, said staff were aware of their needs and they could always discuss concerns. Staff described how they involved consumers and/or representatives in assessment and planning processes and engaged other providers and services. Care planning documentation included summary of consultation with consumers and input from other providers.

Consumers and representatives said they received timely updates on changes in consumer needs or care, and a copy of the care and services plan was provided. Staff explained outcomes of assessments were documented in case conferences, progress notes, and care and service plans which were routinely shared with consumers and representatives. Care planning documentation included summary of care conferences held with representatives.

# 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. | 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. | Not 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

This Quality Standard is Not Compliant, as 4 of the 7 Requirements have been assessed as Not Compliant.

The assessment team recommended Requirements 3(3)(a), 3(3)(b), 3(3)(e), and 3(3)(f) Not Met.

Requirement 3(3)(a)

Feedback from a consumer and a representative reflected a lack of timely, adequate, and effective clinical care in relation to wound care and pain management. Care planning documentation evidenced inconsistencies in adherence with wound care management, with charting demonstrating deterioration of wound condition. Staff were unaware of directives for pain management prior to wound care, and confirmed consumers waited for long periods for clinical staff to attend required dressings. Clinical staff said they would hand over unattended wound care to the next shift, however, it can be missed, and management reported concerns on the level of oversight from senior clinical staff impacting the quality of care.

Whilst staff and documentation demonstrated use of non-pharmacological strategies prior to application of restrictive practices, the service did not demonstrate all consumers subject to restrictive practices had informed consent and tailored behaviour support plans.

The provider’s response states they were aware of the deficiencies in wound management prior to the Site Audit, with continuous improvement plans being implemented at time of assessment. Information has been cross referenced to Standard 2, with further actions to undertake a review of all consumers with wounds and updating documentation with directives and policies. They report the wound for one of the named consumers is now healed and the other consumer is under the care of a wound specialist with improvement being demonstrated.

I acknowledge the provider’s response, explanation, and actions being undertaken. The evidence before me relating to chemical restraint has not reflected impact on consumer care, although I recognise the absence of effective assessment, planning, and legislative consent (considered further within findings for Standard 2). However, I find the service has not demonstrated provision of best practice, safe and effective wound care for the 2 named consumers, with inconsistencies in provision of wound care and documentation. Monitoring and oversight practices failed to identify and take necessary action when deterioration occurred. Clinical staff attributed deficiencies to insufficient staffing numbers and knowledge (considered further within my findings for Standard 7), and management considered it related to under performance of senior clinical staff. Whilst corrective actions have been undertaken for named consumers, and a review of all consumer wounds undertaken, the provider should consider whether improvements are sufficient to prevent recurrence with responsibility for care provision resting with all clinical staff. Furthermore, it will take time to embed changes and ensure ongoing improvement. Accordingly, I find Requirement 3(3)(a) Not Compliant.

Requirement 3(3)(b)

Whilst consumers believed risks were effectively managed, and staff interviewed were knowledgeable of consumer risks and interventions, care planning documentation did not demonstrate the service followed procedures relating to monitoring consumers after falls, managing diabetes, or providing care of urinary catheters. Following falls, care planning documentation for 4 consumers did not demonstrate they were monitored for neurological changes or pain in line with organisational policies despite staff demonstrating awareness of rationale and associated risks. Monitoring of diabetes was not undertaken in line with medical officer directives, and when results were within reportable ranges staff did not always demonstrate following documented action plans. Documentation recorded a consumer with a urinary catheter experienced a delay of 9 days in receiving scheduled care to change the device. Staff attributed care gaps due to high use of agency staff, who may not be familiar with policies and procedures. Management acknowledged findings and lack of clinical oversight to identify risks and ensure they were addressed.

The provider’s response acknowledges deficits with commitment to improvement and to learn from these matters, citing impact from changes within the management team. Actions taken include, but are not limited to, providing memorandum and education to staff, reviewing policies, discussion within staff meetings, developing improved documentation and communication pathways, and capturing actions in continuous improvement plans. A review of named consumers had been conducted to verify there were no adverse outcomes experienced.

I acknowledge the provider’s response, explanation, and actions being undertaken. Whilst the provider has verified there were no adverse outcomes experienced by consumers, I do not consider this reflective of effective risk management practices. Planned actions address knowledge of current staff, but do not address deficiencies in inexperienced or agency staff understanding of practices. Whilst effective clinical oversight may have identified this issue sooner, I remain concerned that clinical staff were aware of the potential for harm by not following directives, but this did not drive escalation for improvement. Actions taken are aimed at improvement in knowledge and practices of current staff, however, the effect is not yet demonstrated or embedded to support new and agency staff. Accordingly, I find Requirement 3(3)(b) Not Compliant.

Requirement 3(3)(e)

Consumers and representatives reported information about wound care was not effective, as there was a lack of consistency in delivery of care. Staff were unaware of directives from wound specialists for one of the consumers and said at times, outcomes of assessments were not shared or documented due to lack of awareness and/or impact from high use of agency staff. A medical report communicating consumer deterioration and changed diagnosis, and specialist reports were not incorporated into care and services plans. One consumer said they felt they often repeated information to staff as they didn’t trust there were effective communication practices between nurses and important information may be missed.

A representative reported a lack of communication between staff resulted in the consumer failing to undertake essential medical preparation for an investigative test, resulting in a rescheduled appointment and delayed diagnosis. Actions taken were not effective, resulting in a second appointment being rescheduled. Although management advised staff were advised of the appointment through an email, this was not followed up, resulting in lack of actions as the nurse on duty was unaware. Care planning documentation did not include record of the appointment or necessary medical preparation, nor the rescheduled date.

The provider’s response acknowledges deficits with commitment to improvement and to learn from these matters, citing impact from changes within the management team. Actions taken include, but are not limited to, improvements in assessment and planning practices and documentation, providing additional oversight during weekday verbal handover meetings, reintroducing a documented handover, and communicating information about risks, complex health issues, and new consumers within a weekly clinical review meeting.

I acknowledge the provider’s response, explanation, and improvement actions being undertaken. However, I find the provider’s actions do not sufficiently address concerns about knowledge and understanding of documentation processes for new and agency staff. Furthermore, I consider it will take time to demonstrate the effectiveness of implemented actions to ensure appointments aren’t missed, and consumers or their representatives no longer feel the need to repeat information to ensure staff awareness. For these reasons, I find Requirement 3(3)(e) Not Compliant.

Requirement 3(3)(f)

Whilst staff could describe referral processes, and consumers reported they had access to a range of health providers and services, documentation did not support referrals were made in a timely manner. Deterioration of wounds did not always trigger referral to a wound care specialist, nor were concerns escalated to the medical officer within reasonable timeframes. Staff attributed delays to agency staff being unaware of the process and lack of clinical oversight.

The provider’s response acknowledges deficits with commitment to improvement and to learn from these matters, citing impact from changes within the management team. The provider has referred to improvements for Requirements 2(3)(b), 2(3)(e) and 3(3)(a) for actions being undertaken, including, but not limited to, auditing wounds, coordinating referrals for named consumers, undertaking education of staff, and monitoring through auditing and increased oversight.

I acknowledge the provider’s response, explanation, and improvement actions being undertaken. Actions within the Plan for continuous improvement are listed against each of the Requirements recommended Not Met, and do not specifically address use of timely and appropriate referral to meet consumer needs. My decision places weight on staff stating they were aware of processes, however, reported inconsistencies in knowledge and awareness of new and agency staff that had not been addressed. The service relies on a workforce made up of newer staff and periodical dependence upon agency staff and actions do not currently address specific needs of a newer workforce. Accordingly, I find Requirement 3(3)(f) Not Compliant.

I have found Requirements 3(3)(c), 3(3)(d), and 3(3)(g) Compliant.

Care planning documentation for consumers receiving palliative care included recommendations from palliative care specialists. Staff described the importance of monitoring and management of comfort and pain, with medications prescribed to manage end of life symptoms. Policies and procedures were available to guide staff practice in provision of palliative care and supporting death and dying with dignity.

Consumers and representatives gave examples of identification and management of changes in consumer condition, with care planning documentation reflecting changes were assessed and monitored. Staff described signs and symptoms of deterioration and actions they would take to escalate concerns. Whilst deterioration in status of wounds did not always trigger a timely response, I have considered this against other evidence brought forward and, on balance, find the service compliant with Requirement 3(3)(d).

Staff received training on infection prevention and control, and could describe signs, symptoms, and management pathways for infections including collection of pathology to ensure appropriate prescribing of antibiotics. Management explained vaccinations were available on clinic days, and monitoring of status was undertaken. The service had not experienced any outbreak since commencement, however, had supports through Infection prevention and control leads, policies, procedures, and outbreak management plans. Infections were reported for monitoring and oversight at organisational level.

# 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

This Quality Standard is Compliant, as 7 of the 7 Requirements have been assessed as Compliant.

Consumers and representatives gave examples of how services and supports aided them to be as independent as possible and supported their well-being. Staff demonstrated familiarity with consumer’s needs, goals, preferences, and supports which were outlined within care planning documentation.

Consumers said they received support when feeling low and were supported through engagement with religious services and visits. Staff outlined how the service’s integrated model of care focused on emotional monitoring and understanding, with staff being provided additional training to upskill. Religious services were included within the lifestyle program, and staff said additional one to one emotional support was provided by lifestyle staff or pastoral care visitors. Emotional, spiritual, and psychological needs and supports were reflected within care planning documentation.

Care planning documentation included information on consumer social supports. Consumers detailed how they were supported to maintain connections with individuals or groups, including within the broader community. Staff explained activities were scheduled in accordance with consumer interests on an individual and group basis.

Staff described communication pathways to share information about consumers, including the daily head of department meetings attended by supervisors who then relay essential information to personnel. Whilst there were inconsistencies noted in consumers’ care and service plans, information was available throughout related assessments. Consumers reported information about them was effectively communicated with relevant service and support staff.

Care planning documentation reflected timely and appropriate referrals to organisations and services to support consumer wellbeing. Consumers explained discussions about referrals being made for them. Staff explained engagement with, and referrals for, other services and supports to meet consumer needs, including volunteers, counsellors, and community groups.

Overall, consumers gave positive feedback about the quality, quantity, and variety of provided meals. Two consumers reported concerns about the quality and temperature of some meals, with drop in quality on weekends, and these were reflected within recorded complaints. Management described the monitoring undertaken and ongoing requests for feedback during consumer meetings. One consumer felt their cultural dietary preferences were not being met, impacting enjoyment, and staff explained how the rotating menu had considered their specific needs with some of the available options, with management advising they would engage further with the consumer. Meals were prepared on site by qualified chefs, who followed a menu designed by the organisation with Dietitian input.

Consumers described the equipment as clean and well maintained, with awareness of processes to report concerns. Personal and lifestyle equipment was observed to be suitable, clean, and well maintained. Staff described scheduled cleaning processes and auditing undertaken to monitor cleanliness and infection control practices.

# 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. | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Quality Standard is Not Compliant, as one of the 3 Requirements have been assessed as Not Compliant.

The assessment team recommended Requirement 5(3)(b) not met, as consumers said they were unable to move freely through indoor areas or access outdoor areas of the service, reporting feeling confined and restricted. Fobs to access security doors had restrictions, and consumers were observed attempting to access the front door or other areas were unsuccessful due to restrictions. Staff advised they did not have sufficient time to support consumers spend time outside beyond the scheduled walking groups. Management advised access to the rooftop lounge was only for consumers paying for additional services, however, acknowledged the impact to consumers in restricting movement through non-premium access areas, recognising full consideration had not been given to determine if restrictions to consumer’s free movement constituted environmental restraint.

The provider’s response acknowledges deficits in relation to restrictive practices, and measures have been taken to ensure consumers have access to enter and exit the service and enjoy surrounding parks, balconies, and the ground floor café. Lifestyle staff will consult with consumers to determine if they would like more scheduled outdoor activities. Enhancements would be undertaken on the balcony area with consultation with consumers, and lifestyle staff would explore additional outdoor activities such as walking groups and bus trips. However, the response reiterated additional service option is required to access the Sky Garden, and consumers who choose not to purchase will not be supported to enter.

I acknowledge the provider’s response and comments in relation to the Sky Garden. I would encourage the provider to ensure there is clear communication to consumers as well as their representatives in relation to the additional packages and access to the Sky Garden upon entry and within reviews, given the feedback about access provided by consumers during the Site Audit. Management advised the assessment team that most consumers were placed on environmental restraint due to misunderstandings by previous management and this has been addressed. Despite the provider’s response, I note there are no included actions relating to this Requirement within the submitted Plan for continuous improvement to ensure improvements are undertaken and effective.

My decision has placed weight on consumers stating and demonstrating they could not freely exit the premises resulting in them feeling confined, even if they could access balconies. The provider has not addressed circumstances of named consumers to demonstrate how their internal review had addressed these issues for the individuals, although they state they have rectified deficits in processes. As the provider has acknowledged deficits, and improvements will take time to embed and evaluate, I find Requirement 5(3)(b) Not Compliant.

I am satisfied Requirements 5(3)(a) and 5(3)(c) are Compliant.

Consumers described the service as modern, warm, welcoming, and easy to navigate. Display screens help consumers find their way throughout the environment and to their rooms. Consumer rooms were personally decorated with photographs, paintings, and personal items. Consumers were observed frequenting communal areas to rest, socialise, or participate in activities.

Consumers said provided furniture, fittings, and equipment were cleaned and maintained regularly. Management said items were still under warranty with limited issues to date and explained schedules for cleaning and maintenance and how repairs were requested. Furniture and fittings were clean and appropriate for consumer use.

# 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. | Not Compliant |

Findings

This Quality Standard is Not Compliant, as one of the 4 Requirements have been assessed as Not Compliant.

The assessment team recommended Requirement 6(3)(d) Not Met, with consumers and representatives saying feedback is recorded and actions initially taken, but issues remain ongoing. Trends in feedback and complaints were not effectively and consistently identified, and management could not demonstrate sustainable improvements being made. While improvement actions were added to the Plan for continuous improvement, some were closed on the date of entry, lacking evaluation of effectiveness of outcomes, including whether there was improvement to the quality of care and services. Management stated the electronic register combined the planned actions and evaluation fields and did not have option for further review once closed. Organisational management attributed deficiencies in reviewing and reporting to poor onboarding instructions for the Facility manager.

The provider’s response acknowledges deficits with commitment to improvement and to learn from these matters, citing impact from changes within the management team. Analysis of feedback recorded within the past 6 months has been undertaken to identify trends and develop continuous improvement actions. Refresher education on corporate feedback processes has been provided to the Facility manager.

I acknowledge the provider’s response and improvement actions. Whilst analysis has been undertaken to identify trends, with concluding statement referencing development of actions including making improvements to capture feedback, reviewing methods to make improvements, and development for Plans for continuous improvement. However, the provider has not submitted evidence of what these improvements or actions look like, and the submitted Plan for continuous improvement only reflects actions arising from the Site Audit report review. I recognise actions to identify trends in feedback and complaints but am not satisfied the evidence before me demonstrates how this will be used to improve the quality of care and services. I also consider it will take time to embed new practices, informed by training, and demonstrate improvement within this Requirement. Accordingly, I find Requirement 6(3)(d) Not Compliant.

I am satisfied the other Requirements in Standard 6 Feedback and complaints are Compliant.

Consumers and representatives said they felt encouraged and supported to provide feedback and make complaints and were aware of available methods. Staff explained written and verbal feedback and complaint processes in place, and outlined how they would encourage and assist consumers as needed. Feedback forms and locked boxes were available, processes outlined in consumer handbooks, and feedback and complaints were reflected in meeting minutes.

Consumers reported awareness of available advocacy and language services, and external supports for complaints. Management explained consumers were informed of access to supports through published information within consumer handbooks, newsletters, and attendance of advocacy services at consumer meetings. Staff were aware of how to engage support services, including translating and interpreting services, advocacy groups, or external complaint avenues.

Overall, consumers and representatives said complaints were addressed and resolved in a timely manner, although some reported the improvements were not effective and there was recurrence of issues (considered further within my findings under Requirement 6(3)(d) above). Staff demonstrated an understanding of the open disclosure process, including an apology. Documentation within the complaint register evidenced use of open disclosure and timely management of complaints in line with the service’s policies and procedures.

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

Findings

This Quality Standard is Not Compliant, as 3 of the 5 Requirements have been assessed as Not Compliant.

The assessment team recommended Requirements 7(3)(a), 7(3)(d), and 7(3)(e) Not Met.

Requirement 7(3)(a)

Consumers, representatives, and staff reported concerns on the impact on consumer care due to the reliance on agency staff and mix of skilled nurses, describing resultant delays in care, lack of knowledge, and lack of familiarity with consumers. Whilst rosters demonstrated appropriate number of staff were scheduled, and the service met legislated nursing requirements, management said they accessed external clinical staff for evening and night shifts whilst progressing with recruitment. The service was not operating at capacity, with potential to accommodate 125 consumers and only 78 were present at time of the Site Audit, and management stated they were staffed to 80 consumer capacity. During establishment, staffing levels were reviewed with every 20 new consumers. Management attributed deficiencies in assessment, planning, and delivery of care to the high use of agency staff and new graduates, adding mentoring for new staff was not always available on scheduled shifts. Staff reported recruitment of large numbers of staff in the 3 months prior to the Site Audit, including care and clinical staff.

The provider’s response states they do not agree deficiencies in consumer care have arisen from workforce planning, numbers, and skill mix, but instead arise from limitations in clinical management oversight. They consider the use of agency staff, reflected on sampled rostering periods, did not reflect excessive use. Ongoing recruitment initiatives continue with successful hiring of staff to cover nearly all clinical shifts. Monitoring is undertaken to ensure timely response to consumer calls for assistance, and the service is meeting care minute requirements and has nurses scheduled on all shifts.

I acknowledge the provider’s response. The provider has a system to determine workforce numbers for current consumer cohort, demonstrated through care minutes and meeting legislated nursing hours. However, I am not satisfied current processes consider the number and mix of staff, resulting in deficiencies in assessment, planning, and delivery of care outlined in Standards 2 and 3. The provider contends deficiencies arose from lack of oversight of staff performance, however, I have placed weight on the feedback from consumers, representatives, and staff reporting lack of knowledge of agency and new staff, and the burden on staff to find time to support staff unfamiliar with consumers and processes. The analysis of agency use provided by the provider supports findings by the assessment team of higher impact on evening and night shifts, with the provider explaining subsequent recruitment to use own staff for nearly all clinical shifts. However, the provider’s response does not address feedback provided to the assessment team of reliance on graduate nurses who require additional time from experienced staff for mentoring and support. Furthermore, this recent recruitment has only addressed rostering levels for the current consumer cohort, with the service operating at just over 60% of allocated places being filled at the time of the Site Audit. Evidence brought forward in the Site Audit report under Requirement 7(3)(d) also references a high turnover of clinical staff, and the provider has not demonstrated established planning to address this nor strategies for staff retention.

Whilst staff were aware of deficiencies in care, actions were not taken by existing staff, onsite management, or organisational management in a timely manner to prevent impact on consumer care. As consumers and representatives have reported the impact on care and well-being, reflected within findings of non-compliance in Standards 2 and 3, I find the service did not demonstrate the number and mix of workforce members enabled the delivery and management of safe and effective care, and Requirement 7(3)(a) is Not Compliant.

Requirement 7(3)(d)

Whilst consumers were confident in the recruitment, training, and support of service-employed staff, they reported a high turnover of staff and reliance on agency staff impacted consistency of clinical knowledge and care delivery. Whilst there was a formal education program for upskilling staff, management were uncertain of status of staff as the educational platform was being upgraded. Available training records did not reflect attendance of external staff, such as agency staff, or strategies to capture clinical staff who did not attend. Management couldn’t demonstrate monitoring or evaluation of effectiveness of training, with identifiable impact on the quality of provided care. Agency orientation and onboarding processes were inconsistent or inadequate, with interviewed staff reporting if received it was combined with handover, creating reliance on other staff for support.

The provider’s response neither accepts nor refutes the findings but explains approved supplier arrangements in place to ensure suitability of agency staff, with provision of orientation and availability of a dedicated information folder to support agency staff. The provider states they do not include agency staff within internal training opportunities. Peer support is available, along with after hours on call support. The provider reiterates they consider deficits in care were not linked to the workforce, instead arising from poor clinical oversight. Audits have been undertaken to determine compliance with mandatory training and staff with overdue training have been contacted and reminded of their obligation to complete essential training, with weekly monitoring undertaken. Orientation checklists were located for agency staff, and a feedback process has been developed and implemented to gather information on orientation and induction processes for agency and new staff.

I acknowledge the provider’s response, explanation, and improvement actions being undertaken. Whilst the provider has submitted orientation checklists for 4 staff, none are complete, with signature of staff not collected on one, and a number of unchecked boxes on the other 3. A statement for staff to confirm their agency has provided necessary training and competency assessment is blank on all 4 sampled forms. Regardless of documentation on the completion of an orientation, given the feedback from consumers, representatives, and other staff relating to deficiencies in knowledge and care of agency staff, I cannot consider the process to be effective. Evidence before me does not reflect whether agency staff were booked for single days or within blocked periods of time, however, I would strongly encourage the provider to ensure all staff, including those provided by agencies, have sufficient training and knowledge to provide safe and quality care. I find the service did not demonstrate the workforce was effectively recruited, trained, equipped and supported to deliver the outcomes required by these standards, reflected within consumer care and feedback from staff and therefore Requirement 7(3)(d) is Not Compliant.

Requirement 7(3)(e)

As the service was newly opened, staff had not yet reached 12 months of employment for annual performance reviews, however, probationary milestones of 30, 60, 90, and 150 days were intended to trigger performance review. Personnel files and staff feedback did not support staff reviews were being undertaken in line with organisational expectations.

The provider’s response neither accepts nor refutes the findings but contends deficiencies were linked to poor clinical management oversight practices. They outline actions taken in response to the findings, including, but not limited to, undertaking an audit of personnel for compliance with reviews and mandatory training completion with development of a tracker for monitoring; reviewing the organisation’s performance development policy to clarify probation periods and reviews, revising the probation and annual performance review template to simplify documentation.

I acknowledge the provider’s response. I find some contradiction within the actions, with the response stating there were no staff with outstanding probation reviews at time of the site visit. However, this is not supported by the continuous improvement activities which state the 100% result is reflective of the number of personnel reviewed in an audit, with actions to ensure there is completion of reviews for all staff by 1 November 2024. The provider’s response duplicates items for Requirements 7(3)(a), 7(3)(d) and 7(3)(e) for each of the Requirements in Standard 7 found Not Met, without clearly reflecting intent of the requirement, or addressing evidence brought forward by the assessment team. Given the deficiencies relating to clinical care, I am also not satisfied the service has demonstrated it has effective processes to identify and manage under performance, including for contracted staff, such as agency nurses. I remain concerned with the provider contending the lack of oversight was the primary reason for deficiencies in clinical care, yet was unable to provide evidence demonstrating monitoring and review of staff performance, including for senior staff. Accordingly, I find Requirement 7(3)(e) Not Compliant.

I am satisfied Requirements 7(3)(b) and 7(3)(c) are Compliant.

Consumers described staff as kind and caring, with respectful interactions and provision of care. Staff received mandatory training on the Aged care code of conduct and customer service related themes. Interactions between staff and consumers were observed as respectful, and the feedback register included positive feedback on staff.

Staff held relevant qualifications, and management explained monitoring for professional body registration, competency assessments, security checks, and ongoing education to meet their roles. Onboarding policies and education were provided to organisational staff, although deficiencies were identified in orientation and monitoring of agency staff (see Requirements 7(3)(d) and 7(3)(e) for further information).

# 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. | Not 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. | Not 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

This Quality Standard is Not Compliant, as 2 of the 5 Requirements have been assessed as Not Compliant.

The assessment team recommended Requirements 8(3)(c), 8(3)(d), and 8(3)(e) Not Met.

Requirement 8(3)(c)

Governance systems were not effective in management and oversight of key areas. Information management practices were not being followed by staff, and this had not been identified or addressed by management. Management cited contributing factors, including a lack of oversight from clinical management, and recent updates to the electronic care management system resulting in lost forms and tasks. Continuous improvement practices did not produce improvements with care and services for consumers, as actions within the Plan for continuous improvement were not effectively updated, reviewed, or evaluated. Workforce governance had not identified impact to consumers due to mix and skills of the workforce, with reliance on agency staff unfamiliar with consumers and work processes, and the service could not demonstrate how staff performance was monitored and evaluated, with inconsistencies in staff onboarding and training. Whilst the organisation’s human resources team provided oversight and support, this had not contributed to improvements at service level. Regulatory compliance policies did not inform staff practice in relation to use of restrictive practices, with management attributing deficiencies to underperformance of clinical management. Feedback and complaint management did not effectively bring about sustained improvement.

The provider’s response acknowledges identified deficits, outlining commitment to continuous improvement. They cite changes within the onsite management team contributed to non-adherence to corporate processes and systems, expressing confidence in the new onsite management team to address this. They believe deficiencies identified are not reflective of failings of organisational governance but lie within individual Requirements within each of the Standards and have requested consideration of positive findings in relation to organisational governance.

I acknowledge the provider’s response. I recognise the availability of policies and procedures within the organisation to inform staff practice and recognise the potential impact of poor oversight processes. The provider’s response references change of management at the service, but places accountability for oversight on one staff member and contends the under performance by this individual has resulted in identified deficiencies. Effective monitoring, oversight, and governance requires multiple systems and levels of monitoring and compliance should not rely on the oversight of just one individual. Whilst the provider references awareness and actions being developed in their response to Requirement 8(3)(e), my decision places weight on the extent of the identified deficiencies and impact to consumer safety experienced over several months prior to the Site Audit. Furthermore, planning for upgrades to information management systems should have support in place to ensure there is no loss of information, even on an interim basis. I find the organisation has not demonstrated the systems in place inform effective governance practices, and accordingly, Requirement 8(3)(c) is Not Compliant.

Requirement 8(3)(d)

Whilst the organisation had risk management systems and practices, these did not support effective management of consumer risks in relation to clinical care. Clinical deficits were not identified, and the framework had not provided improved outcomes for consumers. Management stated they had identified concerns arising from inaccuracies in data within clinical indicator reports, explaining this had been linked to under performance of clinical management. Whilst the service captured incidents through an electronic system, and staff received training in reporting incidents including through SIRS, outcomes from poor clinical care had not been reported until the Site Audit. The service could not demonstrate how the available risk management framework was used to support consumers live their best lives through taking risks of choice.

The provider’s response does not refute the findings, but outlines actions being taken to address deficiencies for named consumers, cross referenced against other impacted Requirements. The Plan for continuous improvement activities are combined for Requirements 8(3)(c), 8(3)(d), and 8(3)(e) and do not specifically address risk management or associated systems.

I acknowledge the provider’s response and actions on an individual basis. However, I find the provider has not demonstrated effectiveness of risk management systems, including oversight, to identify and manage consumer risks. I acknowledge the impact of inaccuracies in reporting and ineffective monitoring, however, remain concerned with the absence of other systems to capture this and support consumer safety and well-being. This has subsequently impacted consumer health and wellbeing, and accordingly, I find Requirement 8(3)(d) Not Compliant.

Requirement 8(3)(e)

The clinical governance framework did not include effective clinical oversight, monitoring, and minimising use of restrictive practices. Staff could not demonstrate consistency in following of policies and procedures and could not outline how they applied the restrictive practices policy in accordance with legislative requirements. Clinical care for consumers was not always in line with best practice, and monitoring and reporting practices were inconsistent, increasing risk to consumers and, in some cases, impacting care. Documentation evidenced inconsistencies in assessment and planning processes. Management attributed a lack of clinical care oversight to underperformance of clinical management, with change of personnel, and a regional quality and compliance coordinator commencing a gap analysis to identify issues, beginning 2 days prior to the Site Audit commencement. Some compliance was demonstrated in relation to antimicrobial stewardship and application of open disclosure.

The provider’s response points out evidence supports the presence of the framework, and therefore has demonstrated compliance. The organisation was aware of the service’s shortcomings, with processes and plans being implemented in response to identified risks. The provider contends the functioning of the framework was considered under Requirement 8(3)(d), whereas 8(3)(e) is about the presence of the clinical governance framework. Actions for improvement had been developed and commenced prior to the Site Audit, with organisational staff on site to undertake investigation and assessment, albeit following a minor delay. The provider cites instability of key operational management positions on site has impacted service performance, and management was aware oversight practices were not meeting expectations.

I acknowledge the provider’s response and actions being undertaken. Throughout the response, the provider has acknowledged deficiencies in clinical oversight, attributed to a clinical management personnel member and new Facility manager. Requirement 8(3)(e) relates to the organisation having clinical governance and safety and quality systems to maintain and improve reliability, safety, and quality of clinical care. The service is a newly commenced service, experiencing ongoing growth in the number of consumers entering requiring care, with reliance upon agency clinical staff whilst undergoing recruitment. It is my view this framework should also have considered enhanced supports for a newly formed management team to effectively lead a team in ensuring understanding and application of the policies and procedures for clinical care.

However, in coming to my decision I have placed weight on the provider’s response in entirety, demonstrating deficiencies in the provision of clinical care had already been identified and actions were being undertaken to assess, investigate, and improve clinical care provision. The provider’s understanding of required improvements in assessment, planning, and delivery of care and documented improvement activities demonstrate there is a clinical governance framework. It is my view the deficiencies in provision of clinical care were linked to workforce performance and governance and risk management practices, considered within Requirements 8(3)(c) and 8(3)(d) and Standard 7. Accordingly, I consider the organisation has demonstrated there is a clinical governance framework to guide staff practice, monitor effectiveness, and drive improvement. I am therefore satisfied Requirement 8(3)(e) is Compliant.

Requirements 8(3)(a) and 8(3)(b) are Compliant.

Consumers described their engagement in operational care and services through feedback in meetings and food focus groups. Management described other pathways for consumer and representative engagement, including surveys, complaint processes and meetings, outlining attempts to establish a consumer advisory body without interest to date. Documentation reflecting input from consumers included meeting minutes and newsletters.

The governing body monitored service performance through regular reporting including clinical indicators, end of month reports, quality initiatives, and incidents. Whilst there were inaccuracies in the reports, the evidence before me demonstrates this had been identified by operational management with actions commenced to assess, investigate and improve the quality of care and services including through providing additional support to the Facility manager and recruitment of new clinical management. The Board was made up of company directors and independent members and included a member with clinical experience. Board meeting minutes reflected analysis of reporting and audits, with benchmarking against other services to understand wider trends.

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)