Performance

Report

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| Name: | Tully & District Nursing Home |
| Commission ID: | 5454 |
| Address: | 13 Bryant Street, TULLY, Queensland, 4854 |
| Activity type: | Site Audit |
| Activity date: | 16 July 2024 to 18 July 2024 |
| Performance report date: | 29 August 2024 |
| Service included in this assessment: | Provider: 556 Tully Nursing Home Inc  Service: 3744 Tully & District Nursing Home |

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 Tully & District Nursing Home (**the service**) has been prepared by Bruce Bassett, 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, observation
* s at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 12 August 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | 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.

* The service must ensure assessment and planning documentation is personalised and effective in recording consumers’ needs and preferences.
* The service must ensure effective personalised care of consumers with changed behaviours and complex care needs.
* The service must ensure meals provided are varied and of suitable quality and quantity.
* The service must ensure appropriate action is taken in response to feedback and complaints and that they are used to improve the quality of care and services.
* The service must ensure the workforce is appropriately trained and supported to provide quality care and services and receive regular monitoring and assessment of their performance.
* The service must ensure it has a appropriate governance systems to meet its regulatory obligations, including in respect of incident management and clinical governance, and ensure a culture of safe, inclusive care.

# Standard 1

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

Findings

Consumers said staff are kind, caring and treat them with dignity and respect. Staff demonstrated knowledge of individual consumers’ identity, culture, and diversity. For example, care staff could speak of consumers’ cultures and identity and spoke fondly of conversations with one particular consumer, a local man with a vast history of the local area and said they enjoy listening to his stories.

Staff were observed treating consumers with respect and in a caring manner, demonstrating patience with meal assistance for those who require it, and having conversations with consumers on topics of interest to them.

Consumers and representatives said consumers’ care and services were delivered with understanding of their needs and preferences while ensuring they feel respected, valued and culturally safe. Staff demonstrated respect for the consumers and an understanding of identity and individuality. The Charter of Aged Care Rights was observed to be displayed within the service.

Consumers said they are supported by staff to exercise choice and independence, by making decisions about how their care and services are delivered and being provided with the opportunity to maintain relationships of choice and make decisions about who else to involve in their care. Staff provided examples of how they help consumers to make choices and assist them to achieve their outcomes.

Consumers said they are supported by staff to take risks and live the best life they can. However, while the service is supporting consumers to take risks and do activities within the community of interest to them, the service was not able to demonstrate appropriate risk assessments have been conducted to identify risk or risk mitigation strategies, or that the outcomes of the risk assessments have been discussed with the consumer. Despite this, the Assessment Team considered the service was able to demonstrate it supports consumers to engage in activities of interest to each consumer to enable them to live the best life they can and are supported to take risks.

Information relating to activities and outings as well as any events at the service are provided to consumers and representatives. Monthly consumer meetings are held to provide consumers with information about changes and activities. Posters and flyers are displayed throughout the service of upcoming outings, scheduled activities, advocacy and support services and the complaints process. The Assessment Team observed the activities schedule, legal services flyers, influenza vaccination flyers, complaints mechanisms, counselling flyers and advocacy services flyers in multiple languages.

Consumers and representatives said they feel comfortable consumers’ information is kept confidential and staff respect consumers’ privacy. Staff described how they respect consumers’ privacy during personal care and personal information is kept confidential and never discussed in front of other consumers or in any communal areas. The Assessment Team observed the doors to consumer rooms closed when staff were providing personal care, staff seeking consent prior to entering a consumer’s room and handover being conducted in a private room with doors closed.

Following consideration of the above information, I have decided that all requirements are compliant and therefore Standard 1 is 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. | 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. | Compliant |

Findings

Review of care planning documentation and consumer and representative interviews demonstrated planning is completed in partnership with consumers and others they wish to be involved. Other health care providers and organisations are included in assessment and planning for consumers where necessary. Staff described the assessment and planning process and how consumers and their representatives are included in this.

The service was able to demonstrate effective processes for communicating changes in care plans with the consumer and staff and providing consumers with a copy of their care plan when requested. Consumers and representatives said staff communicate outcomes of assessment and planning with them. The Assessment Team observed care plans in consumers’ rooms and consumers and representatives said they had a copy of the care plan. Staff advised they have access to care plans through the electronic care management system (ECMS) and are provided with information about the consumer’s care needs in handover meetings. The Assessment Team observed outcomes of assessment and planning are discussed during handover meetings.

Care plans are reviewed every 3 months by a registered nurse (RN), when circumstances change or if there is an incident involving a consumer. Documentation evidenced registered staff are alerted by the ECMS when care documentation is due for review. Consumers and representatives said staff discuss consumers’ care needs and preferences with them and are responsive when there is a change to these. Staff could describe how and when an incident occurs, which triggers a review of the care plan and relevant referrals to allied health professionals (AHPs) when indicated.

Following consideration of the above information, I have decided Requirements 2(3)(c), 2(3)(d) and 2(3)(e) are compliant.

With respect to requirement 2(3)(a), information in the Assessment Team report indicated that while documentation for consumers with high risks such as falls, pain management, time sensitive medication and skin integrity were considered by the service during assessment and care planning, the service did not conduct assessment and planning to ensure care was individualised, particularly in relation to the use of restrictive practices.

The service was not able to demonstrate consumers subject to environmental restraint are identified; that consumers subject to restrictive practices have individualised behaviour support plans; or that the service provides timely information to obtain informed consent for the use of restrictive practices.

The service environment includes a locked memory support unit (MSU) where 19 consumers are subject to an environmental restraint.

Staff said there were several consumers who reside outside the MSU who would not be allowed to leave on their own as this would pose a safety risk. One consumer who is not a resident in the MSU, was found to be subject to environmental restraint by the Assessment Team, and this had not previously been identified by the service.

Management said in response to this feedback, they had not considered this as an environmental restraint. Management said they would use the Commission’s perimeter restraint self-assessment tool to perform a risk assessment for all consumers, however the results were not provided to the Assessment Team prior to the completion of the site audit.

Care documentation for most consumers subject to restrictive practices did not include risk assessments and individualised behaviour support plans (BSP).

A review of care documentation for two named consumers who are subject to chemical and environmental restraints, identified they have incomplete BSPs. For example, the BSPs did not include goals to reduce aggressive behaviour or identified triggers.

Incidents of aggression due to a consumer’s changing behaviour, did not consistently result in a review of the consumer’s BSP to evaluate the effectiveness of strategies used for behaviour management.

Where BSPs were in place, they lacked individualised and personalised strategies to support consumers. Staff did not demonstrate knowledge of any consumers’ documented behaviour support strategies. Staff explained generalised support strategies to support consumers. For example, staff explained they provide food, fluid, toileting, and redirection in response to consumers’ changing behaviours.

Clinical management said not all BSPs have been completed for consumers subject to restrictive practice as they have identified 15 BSPs requiring completion, which is evidenced in the service’s plan for continuous improvement.

The clinical management team said, and documentation evidenced, signed consent from the consumer or their substitute decision maker (SDM) is recorded for the use of restrictive practices. However, the service does not seek consent following the provision of accurate and relevant information about the risks associated with the use of the restrictive practice or strategies used to minimise the use of restrictive practices. As such, consumers subject to restrictive practices or their SDM are not provided with timely information to provide informed consent for the use of the restrictive practice in line with the legislation. For example, documentation evidenced a named consumer’s SDM provided consent for the use of mechanical restraints, however the SDM was not informed of the risks and benefits associated with the use of the restraint or strategies used to reduce the use of the restraint.

A review of the service’s template for obtaining consent did not prompt users to discuss risks associated with the use of restrictive practices or strategies used to minimise the use of restrictive practices with the consumer or SDM prior to gaining consent. In response to this feedback, management revised the template to include risks, benefits and alternative strategies associated with the use of restrictive practices.

In response to the Assessment Team report, the approved provider advised all residents had now been assessed against the Commission’s perimeter restraint self-assessment tool and provided evidence to support this. Informed consent forms for consumers assessed as being subject to restraint are in progress. Actions have been entered into the service’s plan for continuous improvement (PCI) to develop a policy and procedures regarding seeking of informed consent for restrictive practices and training will be provided to staff.

With respect to BSPs for consumers, the response advised an RN has been dedicated to the completion of those outstanding and the preparation of tailored care plans. The service is also researching suitable training for the preparation of BSPs.

I acknowledge the actions taken by the service to address the identified deficiencies. I note, however, that the actions have not been completed and it will take time for them to be implemented and evaluated.

Following consideration of the above information, I have decided the requirement is not compliant.

With respect to requirement 2(3)(b), information in the Assessment Team report indicated consumer care plans evidenced some high-risk assessments are completed, including advance care planning and end of life planning.

Care documentation demonstrated advance care planning is included when it is provided by the consumer. Staff said there is discussion about a consumer’s end of life wishes when a consumer enters the service, at care plan review or if a consumer's condition deteriorates.

However, assessments such as cultural needs, social preferences, likes, and dislikes are perceived as low risk by the service and outsourced to family members and representatives for completion. This process has resulted in delays in completing care planning documents, which have resulted in the needs, goals or preferences of the consumer not being met. For example, a named consumer’s representative said the consumer requires frequent use of therapeutic heat packs to reduce her complex musculoskeletal pain. A strategy for pain relief includes the constant use of heat packs. However, as the service did not conduct timely assessment and planning of the consumer’s preferences, this delayed the implementation of a microwave in the consumers room by ‘about 4 weeks’ leaving them with limited access to pain relief.

Another consumer said she requires a female carer to provide personal hygiene cares, however, this is not reflected in the care plan. The Assessment Team identified a male care staff provided personal hygiene cares to the consumer on Day 3 of the Site Audit.

Clinical staff said they rely on consumers or their representatives to identify the consumer’s cultural needs, goals for clinical and personal cares, and preferences, including dietary preferences. Clinical staff said due to this, there is a delay in completing the care plan.

In response to the Assessment Team report, the service advised it will amend the pre-admission process to include an interview with consumers and their representatives to identify cultural needs, social and daily living preferences and current pain management processes.

The response also advised they have provided additional training to staff regarding end-of-life care planning and will be further developing policies and procedures in regard to obtaining information from consumers regarding their end of life preferences.

Following considering the information in the Assessment Team report and the approved provider response, I have decided the requirement is not compliant as the service is currently unable to demonstrate assessment and planning identifies and addresses the current needs, goals and preferences of consumers.

As two requirements are not compliant, Standard 2 is not 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. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Consumers and representatives said the service is effective in managing high-prevalence risks for consumers. Registered and care staff were able to describe individualised consumer care implemented for managing risks from falling, choking, pain, pressure injuries, and unplanned weight loss. Care documentation evidenced effective management of consumers’ pain, time sensitive medications, skin integrity and risk of falls.

Consumers and representatives said the wishes of consumers nearing end-of-life are honoured, and their comfort and dignity are maintained through discussions with consumers and their representatives, Medical Officers (MO) and anyone else they wish to be included in their care. The Assessment Team report contained examples of effective management of palliative care of consumers.

Care documentation evidenced staff recognise, report, and respond to changes in a consumer’s condition. Registered staff advised actions taken include assessment of the consumer, discussion with the consumer and/or their representative, relevant referrals and transfer to hospital if necessary. Care staff advised they notify registered staff if they have concerns about a consumer’s condition. Registered and care staff described how changes to consumers’ mental, physical, or cognitive wellbeing are discussed at handover and in daily management meetings.

Consumers and representatives said consumers’ care needs and preferences are effectively communicated. Care documentation contained adequate information to support effective and safe care. When a consumer experiences a change in condition, a clinical incident, is transferred to or returned from hospital, registered staff notify the consumer’s representative and MO. Registered and care staff confirmed they receive up to date information about consumers at handover and via the ECMS.

The service demonstrated referrals to other healthcare providers or organisations are made in a timely way and are appropriate. Review of care documentation identified, and consumers and representatives confirmed, other health professionals assess consumers and provide directives for their care as required. Staff described how changes in consumers’ health or well-being would prompt referral to a relevant health professional. Management advised, and care documentation evidenced, the service is supported by a dietitian, MO, physiotherapist, speech pathologist, dietitian, and podiatrist.

The service has protocols and programs for staff and consumers to manage infectious outbreaks and is in the process of appointing new infection prevention and control leads. Staff provided examples of practices to prevent and control infections such as hand hygiene, the use of personal protective equipment and obtaining pathology results prior to commencing antibiotics. The Assessment Team reviewed a current outbreak management plan, policies, and procedures to guide staff in prevention and control of infection and antibiotic management.

Following consideration of the above information, I have decided that requirements 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) are compliant.

With respect to requirement 3(3)(a), the Assessment Team report indicated there was insufficient documentation relating to behaviour management such as triggers and interventions, and care documentation was inconsistent and non-individualised. The service did not identify some consumers as being subject to environmental restraint. Staff did not identify or respond to changing behaviours in consumers with dementia, and incidents of aggression went without review or appropriate reporting. Additionally, the service could not demonstrate overarching clinical/medical policies to guide staff. The clinical management team noted few medical policies and procedures are available to staff to guide them in best practice care. This has led to incidents, for example, of overfeeding through percutaneous endoscopic gastrostomy (PEG) feeding tube.

Staff did not consistently demonstrate how to identify strategies to manage changed behaviours. For example, the Assessment Team observed a named consumer to be verbally aggressive to other consumers. Staff were observed during the Site Audit to be re-directing and using distraction techniques to manage the consumer’s behaviours. The Assessment Team observed these techniques were not effective as the behaviours continued. Staff said they did not know how to manage the consumer’s behaviours but said they would refer to her BSP for strategies. However, a review of the BSP revealed it did not include individualised strategies for behaviour management.

Progress notes evidenced the consumer was reviewed by the Older Persons Mental Health service (OPMH) in November 2023. The Assessment Team requested a copy of the recommendations made by OPMH, however this was not provided. Care documentation did not demonstrate her care plan was reviewed following the OPMH review.

Following feedback, management said they will review BSPs to ensure they reflect individual needs and assessments to support staff in managing changed behaviours.

A named consumer who has PEG feeding risks associated which include skin breakdown, falls, and aspiration. The consumer has a suction machine in her room and protocols around her positioning, the use of bedrails to prevent falls, and a pressure relieving zero gravity mattress. The effectiveness of a zero-gravity mattress relies on the consumer’s torso and legs being in an elevated position, as this ensures she maintains an upright position which reduces the risk of aspiration. The Assessment Team observed the consumer’s legs not in an elevated position throughout the Site Audit and did not find documented evidence in her care plan to reflect this need. The Assessment Team provided feedback to management who said they would investigate this further but did not provide the Assessment Team with a resolution before the site audit was completed.

The consumer’s representative said the consumer often aspirates as staff do not keep her in a sitting position and coughing can last up to 1.5 hours, and staff are regularly required to use suctioning equipment to reduce the risk of aspiration.

Clinical staff said they had not received training on PEG management but could explain how they manage the consumer’s PEG. However, 2 incidents of over-feeding occurred in the last 6 months in December 2023 and June 2024. Documentation evidenced both incidents were recorded, however, there is no documented record of strategies put in place to mitigate the risk of over-feeding and the subsequent risk of aspiration. The consumer’s representative was not notified of the December 2023 over-feeding incident and the clinical team were not aware these are reportable incidents.

The clinical management team said the service did not have a PEG policy. However, a guideline had been created by a registered staff member and observations confirmed the guideline was in the registered staff’s office.

In response to the Assessment Team report, the service advised that information in the report regarding the regular prescribed use of an anti-psychotic for a named consumer was incorrect. I accept this correction.

The service advised changes have been implemented to assist in identifying and addressing changed behaviours in consumers. Upon observation of changed behaviours, the service will conduct pain assessment, delirium screening and behaviour charting for one week with development of a BSP and referral to Dementia Services Australia (DSA) to follow if required. Personalised care plans are being updated with individual needs and assessments. Additionally, the service’s PCI identifies staff who wish to work with consumers with dementia will be provided additional training on dementia care and continuity of staff in the MSU will be prioritised.

With respect to the consumer requiring PEG feeding, the service challenged the assertion that the consumer often aspirates, noting the consumer had no history of hospital admission due to aspiration. The service provided an updated health management assessment for the consumer outlining the regular observations, tests, and care of clinical equipment to be undertaken and detailed instructions for staff regarding management of the PEG and care of the consumer, including monitoring of positioning. Training for staff on PEG feeding was organised and the consumer was reviewed by a dietician. I acknowledge the actions taken by the service to address the concerns raised regarding this consumer.

However, I have decided the requirement is not compliant as the service has been unable to demonstrate effective personalised care of consumers with changed behaviours subsequent to dementia. I acknowledge the actions being undertaken by the service to address this deficiency and note it will take time for the changes to be implemented, evaluated, and become embedded in regular practice.

As one requirement is not compliant, Standard 3 is not 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. | 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

Consumers said the service’s lifestyle and activities program provides them with opportunities to participate in activities of their preference and staff assist them to be as independent as possible. Staff demonstrated knowledge of consumers’ needs, goals and preferences and the support they require to participate in activities or pursue individual interests. Staff demonstrated an understanding of the diverse needs of consumers and described how consumers from the MSU are supported to participate in special or cultural activities in other areas of the services.

The service was able to demonstrate services are provided to support the varying emotional, spiritual and psychological needs of consumers. Staff described a variety of processes for providing emotional, spiritual and psychological support to consumers. Lifestyle staff said consumers can either request the additional support directly or they can be referred by staff who have identified the need.

Consumers and representatives said consumers are supported to take part in a range of activities within the service or go out to visit family, shopping or to engage in activities of interest to them. Staff described the ways in which they support consumers’ relationships with their loved ones. Care planning documentation identified the people important to individual consumers, those people involved in providing care and the activities of interest to the consumer.

Consumers and representatives said staff are aware of consumers’ preferences and needs including engagement with other organisations, to deliver care and support and have a shared approach to their care. Staff explained how they are updated if a consumer’s condition or preferences change via handover and message alerts in the ECMS.

The service demonstrated collaboration with other organisations and services to provide timely and appropriate referrals to meet the care and service requirements of individual consumers.

Consumers and staff said equipment is safe and they know how to report any concerns or issues. The service has processes in place for servicing and replacing equipment. Equipment used to support consumers’ lifestyle activities was observed to be clean, suitable, and well maintained.

Following consideration of the above information, I have decided requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e) and 4(3)(g) are compliant.

With respect to requirement 4(3)(f), information in the Assessment Team report contained information which indicated the service was not able to demonstrate consumers are provided meals of suitable quality or variety. While consumers generally agreed there was sufficient quantity of food within the service, most consumers provided negative feedback regarding the food and said there was lack of choice in the daily menus. The service said it was aware of the concerns in relation to consumer dissatisfaction with meals. However, the service could not demonstrate effective interventions taken in response to improve the quality of food provided. For example, named consumers who were on modified diets, or chose not to eat gluten or meat said their choices were limited or at times there were not options available to suit their preferences.

Management said they have taken the following steps to improve the dining experience:

* Employed a new head chef as the current chef has taken extended leave. Management said the new head chef is due to commence in August 2024.
* Temporarily placed a kitchen staff member in the role of chef to ensure consistency and quality of meals.
* Trialled a new menu and sought feedback from consumers. A review of consumer meeting minutes evidenced discussion around the trialled menu, but it evidenced little feedback from consumers.

Kitchen staff provided the run sheet for the evening meals which displayed consumers who would have a hot option, toasted sandwich or a salad; however, this was the same for each day of the site audit with no obvious consumer choice. Dessert was noted as being fruit and custard each evening with no variety provided.

The Assessment Team observed the lunch service on the second day of the Site Audit. Consumers were observed to be eating in the main dining room. Consumers who required assistance from care staff to eat their meal were placed in front of the television whilst the care staff rotated between assisting consumers. The Assessment Team noted the television was on and the environment was loud. At the end of the lunch service the Assessment Team observed the lunch trolley to have plates with uneaten meals.

The Assessment Team provided feedback to management in relation to the issues identified. Management said they were aware of the issues identified and said there was a new menu sitting with the Board for review which will be implemented when the new chef commences in August 2024. Management said the new menu had not been reviewed by a dietician or had input from consumers.

In response to the Assessment Team response, the service acknowledged food has been an ongoing point of complaint. The response identified actions taken to address the concerns of named consumers within the report. These included review of a named consumer by a dietician and the purchase of gluten free food ingredients.

The response advised a new menu is being developed with feedback from consumers and dieticians and ongoing feedback processes are being developed. A menu selection form for all consumers to select their preferred meal option is being introduced. The service advised the television is no longer on during meal services and music is being played to enhance the dining experience.

The service also provided a copy of a recent (August 2024) food safety report showing full compliance with food safety requirements such as temperature, personal hygiene, storage and delivery.

I acknowledge the actions being implemented by the service to address the identified deficiencies, however, on the evidence available to me, particularly the acknowledged consumer dissatisfaction with meals provided, I have decided the requirement is not compliant.

As one requirement is not compliant, Standard 4 is not 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

The Assessment Team report indicated the service environment is welcoming, with wide unobstructed corridors and all common rooms opening to outdoor areas, providing a light and airy atmosphere. There are several areas for consumers and visitors to relax, socialise and congregate. Consumers have their rooms decorated with furnishings and personal items that reflect individual tastes and styles. The service has an allocated activity room, multiple indoor communal areas and a large outdoor garden area to encourage interaction and well-being. The outdoor area provides spaces for consumers to sit and shelter from the sun or weather in addition to verandas off consumers’ rooms.

The service demonstrated the environment is clean, safe, well maintained and comfortable and that consumers can move freely, both indoors and outdoors. The service has a sheltered garden area, and some consumers have direct access to the outdoors from their room, which are easily accessible, safe and clean, and welcoming to consumers. The MSU has a keypad coded entry door with sliding glass doors in the communal areas, which open onto secure outdoor courtyard gardens with seating allowing consumers safe access to the outdoors.

Consumers and representatives said the furniture, fittings and equipment assist consumers to be independent and are kept clean and well maintained. Cleaning and maintenance are scheduled and monitored by management and responded to in a timely manner. Care staff described the process for cleaning equipment used for providing personal cares and advised how they recorded any issues for the maintenance team to coordinate repairs.

In response to the Assessment Team report, the service’s PCI indicates the service will improve overall signage within the facility, undertake to update all outdoor equipment and furniture and update duty statements for cleaning staff.

Following consideration of the above information, I have decided that Standard 5 is 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. | Not Compliant |

Findings

Consumers and representatives said they are supported to provide feedback and make complaints. Staff and management described how consumers and representatives provide feedback via feedback forms and consumer meetings. Consumer handbooks, newsletters and posters displayed in communal areas facilitate the raising of concerns with management. Consumer meeting minutes dated May and June 2024 demonstrated consumers and representatives provided feedback about meals, lifestyle activities and the provision of clinical care.

Consumers and representatives are provided with information about advocates and external avenues for raising complaints through the consumer handbook and posters and flyers displayed in communal areas around the service. Consumers and representatives said they have used advocacy services to support them in making complaints about the service. While the service does not have information to guide consumers in using language services, staff and consumers described how consumers are supported to communicate and provide feedback and make complaints in their own language.

Following consideration of the above information, I have decided requirements 6(3)(a) and 6(3)(b) are compliant.

With respect to requirement 6(3)(c), information in the Assessment Team report indicated the service does not consistently take action in response to complaints.

The service does not have policies or procedures to guide staff in responding to complaints or practicing open disclosure and was not able to demonstrate timely action is taken in response to complaints. For example, named consumers said they had made complaints regarding the taste and variety of food, but nothing had been done in response.

A named consumer’s representative said they have made numerous complaints to management that staff do not leave the consumer in a sitting up position to reduce the risk of aspiration and choking; do not keep her feet elevated to reduce the risk of her shuffling out of the bed or chair; and do not leave the light off over the bed. The representative said while the service has taken action to keep the consumer in an upright position, the last few months there have still been occasions when he has visited and she has been lying flat, legs not elevated, or the light was shining in the consumer’s eyes.

A review of the service’s complaints and feedback register does not document the above complaints, the actions taken to resolve the complaints or if open disclosure was practiced.

Management demonstrated an understanding of open disclosure, and said they provide an apology when things go wrong. Management said complaints are responded to immediately, however, the outcomes are not always documented.

In response to the Assessment Team feedback management added an action to the service’s Plan for Continuous Improvement (PCI) to develop a complaints register to document complaints and actions taken in response to a complaint. This action has a planned completion date of September 2024. Management said a policy and procedure for complaint management will be implemented by December 2024.

The Assessment Team considered the service was not able to demonstrate complaints or actions taken to address complaints are consistently documented, and the service does not have a policy or procedure to guide staff in their responsibilities and accountabilities in relation to complaint management, including the use of open disclosure.

In response to the Assessment Team report, the service advised a feedback and complaints form and a complaint register have been developed and implemented. Copies of these documents were provided with the response. The service advised processes for the review of complaints has been developed and the policy is being developed. The service’s website is being updated to include a feedback tab. Management have also developed a process for staff to report verbal complaints. These will be documented in the complaints register by management.

I acknowledge the significant actions taken by the service since the site audit, which will assist the service to address the deficiencies. However, I am persuaded at the present time that the service is unable to demonstrate appropriate action is taken in response to complaints and feedback from consumers. I have therefore decided the requirement is not compliant.

In respect of requirement 6(3)(d), the Assessment Team report indicated that management was able to demonstrate some feedback and complaints are used to improve quality of care and services. However, the service was not able to demonstrate embedded systems to ensure feedback and complaints are documented and reviewed to identify areas for improvement.

Management said there is no process to regularly review complaints and feedback to identify trends or areas for improvement or evaluate the effectiveness of actions taken in response to complaints. The service does not have a policy or procedure to guide staff in their responsibilities or accountabilities in relation to feedback and complaints management or continuous improvement activities.

A review of management meeting minutes from June and July 2024 did not demonstrate consumer feedback or complaints are reviewed to identify areas for improvement. The service’s PCI did not identify actions taken by the service in response to consumer feedback or complaints.

A member of the Board was not able to provide an example of how consumer feedback and complaints are used to improve the quality of care and services. A review of Board Meetings minutes did not demonstrate that consumer feedback and complaints are reviewed or used to improve the quality of care and services.

In response to the Assessment Team report, the service advised the complaints register will be reviewed by the Quality Care Advisory Board monthly and this has been implemented.

Following consideration of the above information, I have decided the requirement is not compliant as the service cannot currently demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

As two requirements are not compliant, Standard 6 is not 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. | 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

Most consumers and representatives said there is enough staff and staff come in a timely manner when needed. Management described how the workforce is managed and deployed based on the needs of the consumer. For example, management described how the clinical manager, facility manager (FM) and administration staff review the roster each day to ensure staff are deployed to enable safe and quality care and services. Management provided examples of how staff may be redirected to other areas of the service based on consumer needs.

Management said, and a review of the service’s management system confirmed, the service is meeting the minimum number of care minutes per consumer. Management said they encourage staff to respond to call bells in a timely manner by displaying the call bell analysis report in the staff room and review the deployment of care staff daily to ensure there is enough staff to meet consumer needs.

It should be noted however, review of consumer meeting minutes for May 2024 indicated consumers and representatives had requested more staff on weekends to provide one-on-one time with consumers and conduct activities. Management said they are seeking volunteers to conduct activities on the weekends and spend time with consumers.

The Assessment Team observed staff providing care and services in a kind and considerate way that respects consumers identify, culture and diversity. Most consumers and representatives said staff are kind and caring and care documentation included language that was respectful of the consumer and their identify, culture and diversity.

Following consideration of the above information, I have decided requirements 7(3)(a) and 7(3)(b) are compliant.

With respect to requirement 7(3)(c), the Assessment Team report indicated administration staff were not able to demonstrate that staff competencies were consistently monitored for currency. A review of the service’s training register demonstrated some staff have not obtained the required qualifications or competences to perform their role.

Administration staff were not able to demonstrate an effective process for ensuring criminal history checks, Australian Health Practitioner Regulation Agency (AHPRA) registrations or medication competences remain current. Administration staff said while they have a spreadsheet to monitor this, the spreadsheet is not consistently updated.

A review of staff personnel files indicated staff have not been informed of the Code of Conduct for Aged Care (the Code). Administration staff said, and training records demonstrated, staff have not received education to support, equip and prepare aged care workers to comply with the code.

Management said they have appointed a temporary infection prevention control (IPC) lead; however, the appointed staff member has not completed an infection prevention control course to gain the knowledge required to perform this role.

Management said they are implementing an onboarding checklist that includes all required documentation, training and other procedures when a new staff member commences. A review of the service’s PCI indicates the checklist is due to be implemented by September 2024. The PCI also includes an action to audit all existing staff personnel files against the checklist to identify and rectify any missing information.

In response to this feedback, management said an action was added to the service’s PCI to review and implement the Code. This action is due for completion in September 2024.

In response to the Assessment Team’s report, the service advised the following actions have been completed since the site audit;

* Medication competencies have been completed by registered staff
* The Director of Nursing (DON)/FM has enrolled in the IPC lead course and new IPC leads have been selected to commence training in the course.
* Code of Conduct for Aged Care training was provided at a staff meeting. The full Code was then emailed to employees (with printed copies available). Signed acknowledgement that the Code has been read has been returned by staff.
* A copy of the Code was placed in all care stations in all wings.
* An onboarding checklist was prepared for each new starter including criminal history/NDIS Worker Check and AHPRA registration.
* Management has implemented one designated staff member (Clinical/Quality Nurse) to monitor and control staff training, competencies, and monitoring of registration (APHRA) currency. This also will be a monthly Audit.

Following consideration of the above information, I have decided the actions taken by the service since the site audit address the identified deficiencies and are sustainable. Therefore, I find the requirement compliant.

In respect of requirement 7(3)(d), the Assessment Team report indicated staff were not able to demonstrate a shared understanding of the Quality Standards or their regulatory roles and responsibilities. The service does not have an effective process to monitor staff training and does not have policies or procedures to equip and support staff to deliver the outcomes required by these standards. For example, staff did not have a shared understanding of the serious incident response scheme (SIRS). A review of the incident register and progress notes identified serious incidents that were not identified or reported.

Staff did not have a shared understanding of restrictive practice or their regulatory or legislative responsibilities in the use of restrictive practice and the service was not able to demonstrate that restraint is consistently identified and managed.

The service’s annual training calendar includes topics such as oral hygiene, manual handling, CPR, first aid and infection control. However, training attendance sheets demonstrate low attendance by staff. The Assessment Team report provided examples of training being completed by less than 50% of staff. Management said additional training sessions will be conducted to ensure staff attend the training, however the service has not scheduled the additional training.

The service does not have policies or procedures to guide staff in their responsibilities or accountabilities. For example, the service does not have a clinical governance framework or policies or procedures in relation to incident management, complaints management, or restrictive practices.

In response to the Assessment Team report, the service advised SIRS Training has been completed by the care manager, quality and clinical nurse and the DON/FM. SIRS Training is to be completed by all registered and care staff via the service intranet by 30 Sept 2024.

The staff training register and calendars are to be managed for each respective department. Review of position descriptions has been commenced and will include training requirements for each position. Training to identify what is a restrictive practice and requirements around restrictive practice was provided at a registered staff meeting.

Following consideration of the above information, I have decided the requirement is not compliant as the service is unable to demonstrate staff have completed required training or have a shared understanding of restrictive practices and the SIRS.

In respect of requirement 7(3)(e), the Assessment Team report indicated that while the service was able to demonstrate some effective processes for monitoring staff performance and identifying areas for improvement, the service was not able to demonstrate staff participate in regular assessment of performance.

Management said they identified skin tears as a high prevalence risk and manual handling was identified as a contributing factor. In response to this finding the service engaged a registered training organisation to conduct manual handling training over the next few months. A review of the service’s PCI and interviews with staff confirm training is being conducted.

However, the service was not able to demonstrate effective processes for monitoring the completion of staff performance appraisals. Staff did not have a shared understanding of who is responsible for conducting performance reviews. While most staff said they have participated in a recent performance review, management said many performance appraisals are overdue for completion. Management said they have not conducted all staff performance appraisals and are in the process of scheduling overdue performance appraisals.

Administration staff said team leaders are responsible for conducting performance reviews and management said they were responsible for conducting performance reviews for clinical and care staff. The service does not have a policy or procedure that outlines staff responsibilities in relation to conducting performance appraisals.

A review of the service’s performance appraisal register identified 34 (28%) of the 120 staff have participated in a performance appraisal within the last 12 months.

In response to the Assessment Team report, the service advised their review of the services performance appraisal register identified 60 (50%) out of 120 employees have participated in performance appraisal in the last 8 months. I accept this submission by the service provider.

The service also advised they have updated the performance appraisal form to easily identify staff who have completed performance appraisals and who are due. Employees are now aware of the performance appraisal timeframe as advised in their job description when entering for employment.

Following consideration of the above information, I have decided the requirement is not met as the service was not able to demonstrate staff participate in regular assessment of their performance.

As two requirements are not compliant, Standard 7 is not 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. | Not 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. | Not Compliant |

Findings

Consumers and representatives who attend consumer meetings or are on the consumer advisory body said they are invited, during these meetings, to evaluate the delivery of care and services. Management and a member of the Board described how consumers and representatives participate in the development and evaluation of care and services. A review of the minutes for consumer and consumer advisory committee meetings conducted in May and June 2024 confirmed consumers attend and are invited to evaluate care and services.

Following consideration of this information, I have decided requirement 8(3)(a) is compliant.

With respect to requirement 8(3)(b), the Assessment Team report contained information which indicated the service was not able to demonstrate effective systems for promoting a culture of safe, inclusive and quality care and services.

Management and staff said they do not have policies or procedures to guide them in their responsibilities and accountability in delivering the outcomes required by the Quality Standards or relevant legislation.

Management was not able to demonstrate compliance with regulatory or legal requirements in relation to the use of restrictive practices or reporting serious includes to the SIRS.

Management and staff said they have not received adequate training to understand their roles and responsibilities in delivering the outcomes required by the Quality Standards or legislation. The service was not able to demonstrate effective systems to monitor staff training to ensure staff have the knowledge to deliver the outcomes required by these standards or legislation.

The service does not have effective systems for ensuring incident and complaints data are consistently documented and reported to management and the Board for analysis to identify risks and areas for continuous improvement.

Management said they do not feel supported by the Board to promote a culture of safe, inclusive and quality care and services, as the focus of Board meetings is limited to financial governance.

In response to the Assessment Team report, the service advised since the site audit management have taken steps to develop effective systems to promote a culture of safe, inclusive, and quality care and services. These actions include:

* Onboarding commenced on a new governance/compliance software implemented for the service.
* Quality care advisory body terms of reference have been reviewed to establish the system for analysing incidents, and complaints to identify risks.
* Management have advised the Board more focus needs to be given to clinical governance.
* The clinical governance framework is to be formally documented during the governance/compliance software implementation project.
* Management has implemented an ongoing agenda item on the Aged Care Quality Standards and staff roles and responsibilities at monthly staff meetings for each department.
* Management has a direct email set up for feedback and complaints. This is reviewed daily by senior management at the service.
* The Board chairperson has agreed to monthly meetings with the DON/FM to discuss all clinical matters regarding the service, this will then be discussed in depth at the following Board meeting

Following consideration of the above information, I acknowledge the actions taken by the service since the site audit to increase Board oversight and accountability. However, as management and staff advised they felt a lack of support regarding policies and procedures, regulatory compliance and training, I have decided the requirement is not compliant.

With respect to requirement 8(3)(c), the Assessment Team report indicated that while the service was able to demonstrate effective systems and processes for financial governance, the service was not able to demonstrate effective systems for information management, continuous improvement, workforce governance, regulatory compliance or feedback and complaints.

Financial Governance

The service was able to demonstrate effective systems and process for financial governance. Management and a member of the Board described how the service’s financial budget is reviewed by the Board, and Board meeting minutes demonstrate how applications for large expenditures are submitted to the Board for approval.

Information Management

The service was not able to demonstrate information about consumers’ needs, goals, and preferences are consistently documented to guide staff in delivering safe and effective care and services.

Continuous Improvement

The Assessment Team acknowledge that some of the deficiencies identified in this report had already been identified and management had implemented actions to manage compliance. For example, management has identified the service did not have policies or procedures to guide staff performance. Management said the service engaged an external provider to develop a suite of policies and procedures that are contextualised to the service. Management said, and staff confirmed, the policies and procedures will be implemented by December 2024.

While the service implemented a plan for continuous improvement approximately one month prior to the site audit, the Assessment Team noted that the plan did not contain all actions taken by the service to address deficiencies (such as engaging an external provider to develop policies and procedures) or strategies to evaluate the effectiveness of the actions.

Workforce Governance

The service was not able to demonstrate effective systems to train, support or equip staff to deliver the outcomes required by the Quality Standards or to ensure staff performance is regularly monitored or assessed.

Regulatory Compliance

The service was not able to demonstrate compliance with legislative requirements in relation to the safe use of restrictive practices, staff are informed of their roles and responsibilities in relation to the Code of Conduct for Aged Care and ensure serious incidents or allegations of serious incidents of unreasonable use of force, abuse or neglect are identified, responded to and/or reported to the SIRS.

Feedback and Complaints

The service was not able to demonstrate effective systems for ensuring appropriate action is taken in response to feedback and complaints to identify risks or areas for improvement.

In response to the Assessment Team report, the service advised their continuous improvement plan is being actively used and is central to management meetings and overall management.

The implementation of the new governance/compliance software will assist in ongoing regulatory monitoring and compliance via assurance reporting tools. The service acknowledged the plan is still in its infancy, but committed to ensuring all continuous improvement processes are embedded to address identified deficiencies.

Following consideration of the above information I have decided the requirement is not met as the service is still in the process of implementing new governance/compliance software and it will take time for these systems to become embedded and evaluated for effectiveness.

With respect to requirement 8(3)(d), the Assessment Team report indicated the service was not able to demonstrate an effective incident management system that consistently identifies, responds to, or reports serious incidents to the SIRS. The service does not have policies or procedures to guide staff in incident management or prevention, identifying risk, identifying or responding to abuse or neglect of a consumer or supporting consumers to live the best life they can.

A named consumer said she had informed management a care staff member was rough with her when providing personal hygiene cares. The consumer said she sustained bruising due a care staff member grabbing her arm roughly during personal hygiene cares. In response to this feedback, management said they were aware of the complaint and were able to identify the staff member involved. However, a review of the complaint and incident registers demonstrated the complaint and incident of bruising were not documented, responded to, or reported to the SIRS.

Another named consumer’s care documentation contained a progress note describing an incident involving the consumer speaking aggressively to and striking another consumer. A review of the service’s incident register demonstrated this incident was not identified or reported to the SIRS as a psychological or emotional abuse or unreasonable use of force. Management said they do not have a process to review incidents to identify risk or risk mitigation strategies.

Management did not demonstrate a shared understanding of the SIRS or that medication incidents or allegations of abuse must be reported to the SIRS.

While consumers and representatives said the service supports them to live the life they choose, the Assessment Team identified the service does not have policies or procedures to guide staff practices in supporting consumers to take risk to enable them to live the best life they can. The service was not able to demonstrate that assessments are conducted when consumers choose to take risk to identify risks or risk mitigation strategies.

In response to the Assessment Team report, the service advised a risk framework including policy, procedures, risk matrix and risk register are being developed.

With respect to the consumer subjected to rough handling, the response indicated the consumer refused to identify the staff member concerned. The care worker identified by management no longer works at the service. Training on SIRS and incident management was provided to staff and the incident was added to the complaint register.

The incident concerning a named consumer acting aggressively towards another consumer has been reported to SIRS. The named consumer was reviewed by a geriatrician and her BSP and care plan have been updated to implement the recommendations made. The consumer was also relocated to a new area.

The service is currently implementing a privacy policy consent form for consumers and representatives. It is designed to include a range of information to enable consumers to make decisions and support informed consent. This information will be provided in a form that is understandable for each consumer and barriers to communication are to be considered such as cultural identity, health status, cognitive or sensory ability and language.

The service advised a suite of assessments is undertaken during the admission process and reiterated prior to outings.

Following consideration of the above information, I acknowledge the positive actions taken by the service to address the identified deficiencies since the site audit, however, I have decided the requirement is not compliant as the service could not demonstrate an effective incident management system or a shared understanding of what constitutes a SIRS incident.

With respect to requirement 8(3)(e), the Assessment Team report indicated the service does not have a clinical governance framework or policies or procedures to guide staff in their roles, responsibilities or accountabilities in relation to providing clinical care, including antimicrobial stewardship, minimising the use of restraint or open disclosure.

The service was not able to demonstrate effective systems for identifying and responding to risks associated with health and well-being of the consumer.

While interviews with consumers and representatives demonstrated that open disclosure is practiced when incidents are identified, the service does not have policies and procedures to guide staff in practicing open disclosure.

In response to the Assessment Team report, the service said a clinical governance framework is being prepared in conjunction with the implementation of the new governance/compliance software.

The response advised the service does have policy and procedure in place regarding open disclosure, and antimicrobial stewardship. Copies of these were provided in the response and I accept this submission. The service advised all current staff have access to current policies and procedures and that the assessment Team did not take into consideration or acknowledge these due to the service’s transition to the new governance/compliance software to occur in September 2024. I note in this respect the onus is on the approved provider to demonstrate to the Assessment Team the policies and procedures are in place and accessed by the workforce.

I have decided this requirement is not compliant as the service acknowledges it is preparing the implementation of a new clinical governance framework and staff did not have a shared understanding regarding the service’s current policies and procedures.

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)