Uniting Bernard Austin Lodge Liverpool

Performance Report

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LIVERPOOL NSW 2170  
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**Commission ID:** 0347

**Provider name:** The Uniting Church in Australia Property Trust (NSW)

**Site Audit date:** 20 April 2022 to 22 April 2022

**Date of Performance Report:** 30 May 2022

# Performance report prepared by

Denise McDonald, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the Approved Provider’s response to the Site Audit report received 25 May 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as 6 of the 6 specific requirements have been assessed as Compliant.

Consumers confirmed they were treated with dignity, kindness and respect by staff who were caring, gentle and approachable. Staff were familiar with consumers’ life histories, backgrounds, diversity and cultures. Staff described how consumers’ lifestyle choices and preferences were identified and met by the service. For example, the service used the daily community circle and household model to support consumer choice around activities. The service’s consumer engagement policy and framework emphasised consumer self-determination, cultural continuity and diversity. Staff-consumer interactions were observed to be consistently patient and respectful, with the overall service environment calm and quiet.

The service has policies and procedures which guide staff in the provision of culturally safe care. Staff had been provided with transcultural practice training. Consumers/representatives confirmed staff adapt their delivery of care and services to take into account individual cultural, religious and spiritual needs and preferences. Care plans reflected consumers’ preferences such as; receiving one to one pastoral care, attending religious services, visiting the chapel regularly or spending time alone in their room. Staff understood consumers’ personal, cultural and religious wishes. Staff gave examples of using language cards to communicate with consumers and supporting an Italian consumer to listen to music from their country of origin.

Consumers confirmed that were supported to maintain the relationships that are important to them, to make decisions about service and about how they spend their time. Care plans set out the important relationships and the nominated representatives that consumers wish to involve in their care. Staff outlined various ways they support consumer choice such as; through consumer meetings, in care conferences and at each meal time. Staff support consumers to contact their family members and to arrange visits to the service. The scheduled review of care plans embeds consumer choice and participation in service delivery.

The service has a risk-taking policy and procedure that guides discussions with consumers and representatives about activities involving risk. Care plans showed consumers were supported to evaluate and take risks, where they chose. Staff could describe how they supported specific consumers in activities involving risk. For example, staff described how they support consumers who choose to smoke, by accompanying them to the designated smoking area and monitoring them. Staff were observed to support consumers in accordance with the service’s smoking policy and procedure.

Consumers confirmed they got the information they needed to make decisions about their care and services. Consumers said they received information in a variety of ways, including, when they enter the service, through newsletters, meetings, activity calendars, regular announcements, noticeboards and directly from staff. Staff described how they ensure information is provided to consumers with communication difficulties, for example by emailing information, providing large print font or through use of communication cards. Other staff outlined that representatives are contacted in response to incidents and to discuss routine matters. The service’s welcome pack and consumer handbook contained relevant information for consumers and representatives to inform their decision making about day to day care.

Consumers were satisfied that staff respect and protect their privacy in daily interactions and when providing care such as; toileting and incontinence management. Staff outlined ways they respect personal privacy such as, knocking before entering and keeping doors closed when providing personal care. The service adheres to the organisational policy on protection of personal information. This involved keeping confidential records secure and password protected, having staff and volunteers sign a confidentiality agreement and separating administrative records from clinical records.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant as 5 of the 5 specific requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 2(3)(a) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirement below.

Overall, consumers felt they were partners in the ongoing assessment and planning of the care and services they needed. Consumers described their needs, goals and preferences, which were accurately reflected in care plans and were known by staff. Care planning documents detailed consumers’ medical history, their personal and clinical needs, goals and preferences. Care instructions for staff contained current information relating to care needs such as; pressure injuries and wound management, falls risk and dementia-related behaviours. However, the Assessment Team found the service did not demonstrate that the assessment process consistently monitors or manages pain in consumers.

The service uses a fully integrated electronic care management system. A comprehensive care plan is completed once the assessment process scheduled over 28 days is completed. The care plan is reviewed at least every 3 months and/or as consumer needs change. The service has policies and procedures which guide the assessment and planning process. This includes advance care and end of life planning.

Staff could describe the service’s processes for assessment and planning including advance care and end of life discussions. Thirty-six of 38 consumers had an advance care directive which had been completed within the last 12 months, in consultation with the consumer/representative.

Care documents confirmed the involvement of a range of other individuals and organisations in assessment and planning including; medical officers, speech pathologists, physiotherapists and dieticians. Consumers and representatives confirmed their ongoing partnership in assessment and planning, including in reviews and through day to day discussions and updates. Staff understood referral processes and how the input of medical officers and allied health professionals are integrated into consumer care. Staff advised that consumers choose who is involved in their care and services. Management outlined how the review of care and services happens continuously, through direct daily conversations and regular care conferences with consumers and representatives. The organisation’s policies state consumers and representatives are partners in care planning, and observations during the Site Audit confirmed the involvement of various health professionals.

Care plans effectively communicated the outcomes of assessment and planning to those involved in the delivery of care and services. For example, care plans communicated assessments and directions from physiotherapists, podiatrists, wound consultants and medical officers. Consumers and representatives confirmed they discussed care needs and preferences in care conferences, with these discussions documented. Consumers and representatives could access care plans, if needed. Staff said they had received training to develop their skills in care consultation and how to communicate the outcomes of assessments. Staff were observed accessing the electronic care management system and information being exchanged during shift handover.

The service could demonstrate that care and services were regularly reviewed for effectiveness, when circumstances change or when incidents impacted the needs, goals and preferences of consumers. The organisation’s assessment and care planning policies and procedures set out the review processes, including the responsibility of staff to ensure assessment and planning reflects the consumer’s current care needs. Care plans showed the service reviews them on a regular basis and when consumer circumstances changed, or incidents occurred. For example, care plans showed reviews occurred when a consumer returned from hospital after sustaining a fracture and when another consumer reported chronic pain. Consumers said their care plans were regularly reviewed by the service, while registered staff outlined the 3 monthly review schedule and described how incidents, such as a consumer fall, would trigger a review of their care plan.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

The Assessment Team found the service did not always demonstrate that assessment and planning considered risks relating to pain management and choking. Evidence presented by the Assessment Team relevant to the Requirement included:

* For 2 consumers experiencing strong pain, staff did not appear to consistently record pain scores after medication was administered, to determine whether the pain relief was effective. Two care staff confirmed one of these consumers screamed a lot from their pain. Management confirmed that pain-related behaviours would be addressed in the consumer’s care plan.
* The nutrition assessment for one consumer at risk of choking identified risk mitigation strategies such as adapted seating and mealtime assistance. However, care staff did not appear to seat them correctly during meal time or notice they were coughing, which was a trigger for a new speech pathology assessment.
* Staff could explain how assessment and planning informed the delivery of care and services for consumers including in relation to risks. Staff were aware of the escalation protocols when they identified changes or deterioration in a consumer’s condition.
* Most consumers/representatives were satisfied with the level of care they received and said they were notified of changes in care and were involved in decision-making.

The Approved Provider’s response acknowledged there were opportunities for improvement however, they refuted the finding of the Assessment Team that the Requirement was Not Met, based on the evidence presented. The Approved Provider submitted additional evidence in support of their assessment and planning processes and a copy of new amendments to the service’s plan for continuous improvement which included actions related to assessment and planning. The Approved Provider advised:

* The service has a robust pain management system which includes a comprehensive pain assessment using validated assessment tools and correct diagnosis to support an individualised pain management plan which is implemented by clinical staff.
* The consumers experiencing pain were being actively assessed, monitored and managed for pain in consultation with the medical officer and clinical staff.
* One consumer’s representative and the medical officer had recently discussed the consumer’s pain and agreed their pain can only be controlled to a certain level.
* The consumer’s pain chart was active and stored in the electronic care management system.
* The pain management plans were developed in consultation with the consumers/representatives and their medical officer.

A number of issues identified by the Assessment Team, such as effective pain and choking risk management, relate to the delivery of effective personal and clinical care and I have considered these under Standard 3(3)(a). I note the additional records provided by the service indicate comprehensive assessment and planning has been, and continues to be, undertaken to inform the care needs for the relevant consumers. I find that the service applies assessment and planning, (including consideration of risks) to inform the delivery of safe and effective care and services.

I find the service Compliant with this Requirement, based on the evidence summarised above.

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as one of the 7 specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirement 3(3)(a). Reasons for the findings are detailed in the relevant Requirement below.

The Assessment Team also recommended 3(3)(g) as not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Consumers/representatives said their personal and clinical care needs were mostly met. The service demonstrated it managed high impact and high prevalence risks effectively, however the Assessment Team identified a number of deficits which have been addressed in Requirement 3(3)(a). Care plans contained evidence the service identifies risks to consumer health and well-being and implements appropriate mitigation strategies. Staff confirmed they rely on care plans in their management of complex health conditions. Management advised the key clinical risks at the service included; weight, falls, wounds, behaviour and medication monitoring.

Consumers and representatives were confident the service would meet their end of life needs. Consumer files contained consumers Advance Care Directives and care plans contained detailed instructions regarding sampled consumer’s wishes for treatment, pain management and presence of loved ones. Staff knew where to access consumers’ end of life preferences, could describe how end of life care focuses on maximising consumer comfort and the strategies used to achieve this. Staff were guided by policies and procedures in their provision of end of life care and management confirmed that a registered nurse is on-site when a consumer is palliating.

Generally, the service effectively documents and communicates information about consumers’ condition, needs and preferences to all those involved in their care. Deficits in documenting the efficacy of pain medication have been considered under Requirement 3(3)(a) below. Progress notes confirmed information is shared between the service, medical professionals and other providers as required. Consumers confirmed that staff know their care needs and preferences. Staff outlined the information sharing processes followed when consumers move between the hospital and the service and confirmed representatives and doctors were informed if a consumer’s condition changes. Observations confirmed the service ensures information about changes in consumer needs or condition are shared via handovers, learning circles and electronic alerts on the Electronic care management system.

Staff were guided by referral policies and procedures and progress notes indicated these were followed by staff. Timely and appropriate referrals were evidenced in consumer care plans including referrals to allied health providers, geriatricians, dementia support services and other specialists. Consumers and representatives confirmed consumers have access to the health professionals they need. Staff outlined how the advice and recommendations made by other professionals informs care and services, such as in the case of mobility/ transfer needs, wound care and dietary plans.

The service was able to demonstrate they practiced minimisation of risks through implementing standard and transmission-based precautions to prevent infections and promote antimicrobial stewardship. The service has documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. An Outbreak Management Plan supported the service’s preparedness in the event of a COVID-19 outbreak.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team found the service did not consistently provide safe and effective personal and clinical care that is best practice, individually-tailored or optimised for consumer health and wellbeing. While, most consumers/ representatives felt they received safe and effective personal and clinical care, the Assessment Team identified several deficits in relation to pain management and restrictive practices. Evidence presented by the Assessment Team relevant to the finding included:

* Staff and management did not have shared understanding of what constitutes chemical restrictive practices. Staff were not recording the effectiveness of ‘as needed’ psychotropic medications after they were administered.
* Management considered the signed authorisation for the restraint constituted an ‘ongoing’ consent and did not seek consent when giving consumers those medications.
* The service did not review the use of psychotropics on a regular basis. For example, 2 consumers had been prescribed psychotropics for 2 years and 11 years, respectively, but the use of the medications had been reviewed and informed consent gained only annually in that time. The consumers’ Behaviour Support Plans contained alternative strategies to be used prior to psychotropic use, but progress notes did not show these strategies had been used in practice. A third consumer’s antipsychotic drug prescribed for dizziness and nausea more than two years ago was ceased during the Site Audit, despite having been subject to review and continued by an MO 2 weeks prior to the Site Audit.
* A consumer’s care planning documentation showed the consumer takes psychotropic drugs however the consumer was not listed on the psychotropics register.
* Two consumers’ pain management was not consistent with best practice. Consumers reported pain and were administered analgesia however, there was not always any pain scoring or charting to determine whether pain management was effective. Care planning documentation showed regular review by the medical officer however, one consumer’s analgesic patch was not recorded on the psychotropics register.
* Care staff were not aware that coughing during meal times indicated a heightened choking risk to a consumer, despite their care plan expressly stating they were at risk and that coughing during eating should trigger a new speech pathology assessment. Staff did not respond appropriately to the coughing during feeding and did not position the consumer correctly at meal time. When raised with management, staff were immediately corrected and given guidance, with further training scheduled during the site audit.
* A consumer requiring a Continuous Positive Airway Pressure (CPAP) machine to assist with their breathing at night time said new staff did not know how to fit the aid correctly resulting in the consumer not sleeping well. The consumer reported feeling scared when going to sleep, as a result. When raised with management, a toolbox education session and staff training on using CPAP machines was provided. An undertaking was given to check that night staff were competent in using the CPAP machine.

The Approved Provider’s response acknowledged there were opportunities for improvement however, they refuted the finding of the Assessment Team that the Requirement was Not Met, based on the evidence presented. The Approved Provider submitted additional evidence in support of the care provided at the service and a copy of new amendments to the service’s plan for continuous improvement which included actions related to care delivery. The Approved Provider advised:

* The service has a robust pain management system which includes a comprehensive pain assessment using validated assessment tools and correct diagnosis to support an individualised pain management plan which is implemented by clinical staff.
* All consumers experiencing pain were being actively assessed, monitored and managed for pain in consultation with the medical officer and clinical staff.
* The consumers pain chart was active and stored in the electronic care management system.
* One consumer’s representative and the medical officer had recently discussed the consumer’s pain and had agreed their pain can only be controlled to a certain level.
* Where a medical officer prescribes psychotropic medication, consent is required by the consumer/representative, regardless of whether it is considered a chemical restraint. Consumers/representatives are all made aware of the risks and consequences of all medication. In each case, alternative management strategies are identified and tried.
* The service refers to the Therapeutic guidelines in determining whether a psychotropic medication is clinically indicated with an appropriate diagnosis.
* All consumers receiving psychotropic medication had a diagnosis, behaviour support plan and an up to date medication review.
* The use of psychotropic medication is reviewed every 3 months unless it is newly prescribed, in which case it is reviewed after 2 weeks. Consideration is given to ceasing or minimising the use of psychotropic medication at every review.
* The service acknowledged there could be further documented instruction and training in relation to one consumer with an identified choking risk.

While minor discrepancies in documentation were identified by the Assessment Team, I am satisfied the service has managed pain and prescribed medication in line with best practice. I acknowledge the service has either, completed corrective actions, or included corrective actions to be undertaken on the service’s continuous improvement plan. While the majority of evidence presented supports the provision of safe and effective personal and clinical care, there were instances identified where care was not in line with best practice. At the time of the site audit a consumer with an identified choking risk was observed not to be assisted with their meal in accordance with their care plan and another consumer expressed credible anxiety about new staff not correctly setting up their CPAP machine for the night.

This Standard requires that each consumer gets safe and effective personal and clinical care that is best practice, tailored to their needs and optimises their health and well-being. I therefore find the service Non-compliant with this Requirement, based on the evidence summarised above.

### Requirement 3(3)(b) Compliant

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

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

**Requirement 3(3)(e)** **Compliant**

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

The Assessment Team found the service promoted good antimicrobial stewardship but was unable to demonstrate a consistent approach to infection prevention and control in relation to the risk of transmission of COVID-19. The service did not appear to follow their policy or the directives from the Department of Health. The service did not always appear to isolate and monitor exposed consumers or alert visitors to an exposure risk. Evidence presented by the Assessment Team relevant to the finding included:

* The service gave inconsistent advice to the Assessment Team about whether there were any COVID-19 positive or isolating consumers at the service. Prior to entering the service, the Assessment Team were advised there were no positive or isolating consumers, despite two staff members recently testing positive. On the second day of the site audit, a registered staff member advised there were two isolating consumers who had been symptomatic for a few days. Management confirmed the consumers were isolating.
* No personal protective equipment or warnings were found outside the consumers’ rooms to inform others of the infection risk. Staff advised they were aware of the risk from handovers. Both consumers had tested negative using a Rapid Antigen Test and had been seen by the doctor. Management advised one consumer was due to come out of isolation the next day and the other consumer had three days to go.
* A third consumer was isolating with COVID19 symptoms on the third day of the Site Audit and a table with personal protective equipment was observed outside their room. The Assessment Team observed a staff member leading a visitor to their room, unlocking the door and the visitor entered the room without personal protective equipment. The visitor had not been informed the consumer was isolating. Another staff member intervened to ask the visitor to use personal protective equipment as the consumer was in isolation. Management did not provide a response when the incident was put to them.

The Approved Provider’s response acknowledged there were opportunities for improvement however, they refuted the finding of the Assessment Team that the Requirement was Not Met, based on the evidence presented. The Approved Provider submitted additional evidence about the issues identified and provided a copy of new amendments to the service’s plan for continuous improvement which included actions to address these issues. The Approved Provider advised:

* They acknowledge there was some minor confusion in communication with the Assessment Team in relation to any isolating consumers, during the site entry checklist interviews on subsequent days.
* The particular consumers were feeling unwell and isolating out of caution and had returned negative antigen tests for COVID-19.
* They acknowledge there should have been personal protective equipment placed outside the rooms of the isolating consumers during the first day of the site audit however, this was corrected by the second day of the audit. Appropriate personal protective equipment was available outside the rooms and posters promoting infection control measures were displayed around the service to remind staff.
* The authorised representative for one isolating consumer had been informed about their circumstances, however another family member that was unaware they were isolating visited the consumer. A staff member intervened and it is their belief they did implement the correct protocols.
* The service has a current Outbreak Management Plan which allows for some flexibility in managing risk. Staff are regularly reminded about infection risks and controls in place at huddles and shift handovers. Registered staff and management monitor compliance throughout shifts. Previous infection control monitoring inspections over the last two years did not identify any adverse findings or improvement actions.
* The service is one of the few services in the local health region that has not yet had any COVID-19 positive cases in consumers, which is evidence of good infection control practices.

I note the Assessment Team identified lapses in implementing infection control measures in accordance with the service’s own policies. These lapses were minor and not systemic in nature and were corrected during the site audit. I note the service’s good performance record in preventing COVID-19 cases among consumers. I further note the service has used the identified lapses to inform actions on the service’s continuous improvement plan. Overall, I find that the service demonstrated the minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection.

I find the service Compliant with this Requirement, based on the evidence summarised above.

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as 7 of the 7 specific requirements have been assessed as Compliant.

Consumers confirmed they received the support needed to do activities they enjoy, inside and outside the service, including going on community outings and maintaining close relationships. Consumers said the lifestyle program meets their lifestyle needs and staff assist them to participate in additional independent activities of interest. Consumers said the service regularly seeks feedback in relation to the lifestyle activities and they felt their preferences were reflected in the care and services provided.

Care planning documentation contained information about consumers preferred activities, and preferences for daily living, as well as the support required from staff to ensure their preferences are met. Care plans detailed consumer’s support needs such as; mobility assistance and mobile oxygen equipment. Care plan information was consistent with current feedback from consumers.

Staff demonstrated a clear understanding of what was important to specific consumers and what they liked to do. Staff confirmed the lifestyle program was evaluated on an ongoing basis using direct feedback from consumers/ representatives. Lifestyle activity calendars were sighted throughout the service and consumers were observed participating in a range of activities.

The service supported each consumer’s emotional, spiritual and psychological well-being. Consumers said their emotional, spiritual and psychological well-being was well supported within and outside the service. Care planning documents contained information about the spiritual, religious and mental well-being of consumers and consumers confirmed that staff support these needs. Staff said they know consumers and can recognise when they felt agitated or unwell and, as they usually know why they might be feeling low, they are able to provide emotional support. The lifestyle program contains activities that support consumer wellbeing and includes weekly chapel services, one-on-one and group activities and a visiting psychologist who services consumers.

Consumers confirmed they received services and supports for daily living that enabled them to participate in the service and wider communities, enjoy relationships and do things of interest to them. Consumers described being supported to; participate in communal activities, share meals, maintain relationships with their spouse, read books from the library and listen to cultural music. Care plans evidenced consumer participation in their preferred activities and listed the consumers’ important relationships. Staff knew consumer’s important relationships and explained how they helped them to maintain contact during the pandemic such as through; phone and video calls, other electronic devices and window visits. Lifestyle staff advised that external bus trips to local areas had resumed and these were popular with consumers. Consumers were observed to have copies of the latest activity calendar.

Information about the consumer’s condition, needs and preferences was effectively communicated within the organisation, and with others involved in their care. Consumers confirmed that information was communicated effectively to staff and to others involved in their care. Consumers said staff know them well and they do not need to repeat their needs. Care documentation contained accurate information about consumers’ current condition and needs, to enable the provision of effective daily living support. Staff described their use of progress notes, handovers and direct briefings with supervisors to communicate information to their colleagues.

The service has policies and procedures related to the referral to external services. The lifestyle coordinator identified a range of organisations, services and supports that consumers were referred to as needed. The service has its own hair salon which consumers could use. Care plans contained evidence of referrals to individuals and external organisations for lifestyle services.

Consumers were generally satisfied with the quality and quantity of meals provided at the service. Consumers said their dietary requirements and preferences were catered for, and this was confirmed by kitchen and care staff. Care planning documents showed dietary requirements and preferences were recorded, including where they prefer to eat their meals. Catering and care staff outlined how dietary requirements were documented and communicated to kitchen staff, with clinical staff responsible for inputting changes in dietary needs to the electronic care management system and providing a report the kitchen. The chef demonstrated a thorough knowledge of specific consumer’s preferences and confirmed they met with management regularly to review meals. Kitchen staff confirmed they received information about dietary requirements and preferences. The menu displayed was presented in a small font, making it difficult for some consumers to read however, staff described the menu to these consumers. Mealtimes did not appear to feature a lot of social engagement and a lot of leftovers were seen at one meal. It was observed that staff did not engage with consumers during a meal and the meals were not delivered to seated diners in a way that enabled them to eat together. Consumers taking their meals in their rooms were required to eat 45 minutes after everyone else. The kitchen was observed to be clean and tidy and a copy of the current Food Business License was displayed.

Mobility and lifestyle equipment including; wheelchairs, books, magazines, appliances and games were observed to be clean, suited to purpose and well-maintained. Consumers said their room equipment and medical equipment were also well-maintained. A cat resided in the service and its hutch, bed and bowls were clean and did not impede consumer mobility.

The service has a preventative maintenance schedule and reactive maintenance process. Staff knew the process for requesting cleaning or maintenance and confirmed that management was responsive to requests for repair or replacement of existing equipment or the purchase of new items. The service conducts regular inspections on all equipment to ensure operational integrity and safety.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as 3 of the 3 specific requirements have been assessed as Compliant.

The service environment was welcoming, easy to understand, and optimised each consumer’s sense of belonging, independence, interaction and function. Dementia enabling principles of design were evident and there was safe freedom of movement both indoors and outdoors. Consumers all stated they felt at home and it was an enjoyable place to live. Consumers’ rooms were decorated with personal belongings and their own photos and artwork.

The service had a number of spacious communal indoor areas where consumers congregated to participate in activities, socialise and sit quietly. There is a centralised area at the front of the building and a dining room where most consumers come to eat each meal. Inside the service is a safe environment where consumers move from their rooms, assisted with wide corridors, hand railing and walkways equipped with signs. Among the several courtyards and gardens, there are shaded areas and outdoor furniture. There is a main entrance where visitors sign in and complete COVID-19 screening processes. These screening processes include; completing a rapid-antigen test, temperature checking, and issue of personal protective equipment. An electronic sign-in system is completed by each visitor, declaring they are safe to visit the service.

The service environment was safe, clean and well maintained and allowed consumers to move freely both indoors and outdoors. The temperature was maintained at comfortable levels. Corridors were observed to allow clear and safe movement for consumers and representatives. The external walkways, gardens and car park were well maintained. External pathways were level and free from trip hazards.

Whilst there were security measures in place, consumers could freely access internal areas, including the courtyards. Documentation confirmed fire systems and equipment were part of the preventative maintenance schedule and there were multiple fire emergency plans with instructions throughout the service and all emergency lighting was working. The laundry services were observed to follow a clean, consistent and hygienic process, with dirty and clean washing clearly segregated and managed appropriately.

The service has an on-site maintenance manager who described how all maintenance updates are recorded, actioned and managed. The maintenance schedule and maintenance folder can be accessed by all maintenance staff at the start of each shift and all pending maintenance requests are displayed online as written by staff. Once the task is completed, the maintenance manager will sign off on the register and inform the staff or consumer accordingly. The cleaning area manager described their daily cleaning regimes and provided cleaning schedules, cleaning rosters and a centralised cleaning diary for their areas of responsibility of the service.

Maintenance documentation showed issues are addressed in a timely manner. The internal maintenance log showed routine inspections of various areas, furniture and equipment, were undertaken by maintenance staff and signed off with comments.

The service demonstrated that furniture, fittings and equipment were safe, clean, well maintained and suitable for consumers to use. Consumers felt the furniture, fittings and equipment were safe, clean, well maintained and suitable for them. Consumers said they felt safe when staff used mobility or transfer equipment on them. Consumers who required mobility aids were observed using them freely and had access to them when needed. Consumers had individual slings and walking belts and there was no communal sharing of equipment. Lifting equipment is maintained and cleaned between use. Disinfectant wipes were available where equipment is shared.

Management and maintenance staff advised that furniture, fittings and equipment are assessed for suitability prior to purchase to meet consumers’ personal and clinical needs. A test and tag system were used for all new equipment. Once approved for use, it is tagged to alert staff and consumers that the equipment is safe to use.

The service has a working call bell system. Management said they receive a call bell response report daily and consumers indicated they don’t have to wait more than 5 minutes for staff to respond to call bells. The service has a fire detection and alarm system which is tested and compliant. The maintenance program included planned, periodic and ad hoc maintenance in response to maintenance requests.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Compliant as 4 of the 4 specific requirements have been assessed as Compliant.

The service was able to demonstrate that consumers, representatives and staff are encouraged and supported to provide feedback and make complaints.

Generally, consumers felt encouraged and supported to give feedback and make complaints, and that appropriate action was taken. Consumers and representatives confirmed they were aware of other avenues for raising complaints such as; the Aged Care Quality and Safety Commission, the National Aged Care Advocacy Line, through family/friends or an advocacy service. All consumers and representatives said they were comfortable raising concerns with staff or management in the first instance but would escalate their complaint accordingly, if it was not resolved to their satisfaction.

The service has policies and processes in place to promote and support consumers and representatives to provide feedback and make complaints, and these are used to continually improve the care and services provided. On entry to the service consumers received information about the complaints and feedback processes. They are reminded of these processes at consumer meetings and during other discussions with staff and management.

Staff knew the internal and external complaints avenues, the advocacy and translation services available to consumers and representatives. Staff said consumers and representatives were shown where to find the feedback forms and lodgement box and said they regularly encourage consumers to use them. Staff described how they assist consumers who have a cognitive impairment or difficulty communicating to raise a complaint or provide feedback.

The service was able to demonstrate that appropriate and timely action is taken in response to complaints, and an open disclosure process is applied when things go wrong. Most consumers and representatives sampled said management promptly addresses and resolves their concerns following the making of a complaint or when an incident has occurred. Consumers and representatives confirmed that management and/or staff provide an apology upon the making of the complaint or when things go wrong. Staff confirmed they would escalate all complaints to senior clinical personnel or management for investigation and follow-up.

Staff confirmed they had received training on open disclosure and demonstrated a common understanding of the principles of open disclosure, including providing an apology to the impacted person(s), and implementing actions to prevent recurrence of the incident or complaint. Management were able to give examples of recent actions taken in response to complaints and how an open disclosure process was applied.

The service was able to demonstrate that most feedback and complaints were analysed and used to improve the quality of care and services. Management described the main areas of consumer complaints and what was done to improve the quality of care and services. Consumers and representatives were confident that feedback and complaints were used to improve the care and services and they were able to describe specific changes that had been implemented after complaints. Proposed improvement actions were discussed and evaluated in consultation with consumers and representatives.

Staff described examples of improvements made in relation to addressing vacant shifts and maintaining the necessary consumer care. However, a disconnect was noted between the mostly complimentary entries in the complaints and comments book maintained by the kitchen and the service’s complaints register, which had a number of food related complaints.

The complaints register demonstrates that complaints, feedback, suggestions and incidents have been documented, along with planned improvement actions, dedicated timeframes and evaluation notes.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

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

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Compliant as 5 of the 5 specific requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 7(3)(c) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Most sampled consumers considered they got quality care and services when needed from people who were knowledgeable, capable and caring.

Generally, consumers and representatives said that while there have been some staffing shortages recently, they could not identify any significant impacts on the provision of their care and services. Several consumers indicated they did not have to wait long for a response when they rung the call bell.

Management advised roster deficits had significantly reduced and all shifts are now being covered. Agency staff are sought if needed and wherever possible the same staff are requested to ensure continuity of care. There is ongoing recruitment to address the vacant shifts and unplanned leave. Staff reported some staff shortages however, they advised these have not impacted on consumers’ needs and preferences. Staff said they have sufficient time to complete their duties each day and confirmed all vacant shifts are filled. They said during busy times, they work as a team to complete tasks and meet consumers’ needs.

The call bell system showed that out of 13,000 calls over the previous 3 months: 89% of responses were less than 5 minutes, 9% were within 5 to 15 minutes, 1% were within 15 to 30 minutes.

The service could show the workforce interacted with consumers in a kind and caring manner, and that staff were respectful of each consumer’s identity, culture and diversity. Consumers confirmed that staff were respectful, kind and caring towards them. Staff were observed interacting with consumers in the corridors and at mealtimes, and it was evident they were kind and respectful. Staff were observed referring to consumers by their preferred name and engaging in friendly and familiar conversations.

Management explained all recruited staff must meet the minimum qualification and registration requirements for their respective role and have a current criminal history check completed. The orientation and training processes in place include; mandatory training, competency assessments and role specific training. New staff orientation and onboarding processes support staff integration and competence, through buddy shifts and the probationary period, staff capabilities are assessed, and additional training is provided, where necessary.

Staff complete monthly and annual mandatory training, competency assessments, and online training sessions, when required by the service. Training topics include; infection control, manual handling, restrictive practices, diversity, culturally appropriate care, food safety, dementia, challenging behaviours, elder abuse, reportable incidents, serious incident reporting, open disclosure, dignity of risk, antimicrobial stewardship and quality.

The service has documented policies and procedures that guide the management of the workforce, the selection and recruitment of new staff, orientation and probationary processes, monitoring of staff performance and the performance management of staff - when performance issues are identified.

The service regularly assessed, monitored and reviewed the performance of the workforce. Performance reviews are conducted every year and on an as required basis. Management advised staff performance is monitored through observations, competencies, such as manual handling, hand hygiene and medication administration, through the analysis of internal audits and clinical data, and consumer/representative and staff feedback.

The service’s performance appraisal register confirmed staff performance reviews had been completed according to the schedule.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team found the service could not demonstrate all members of the workforce were competent or had the knowledge they needed to effectively perform their roles. While the service provided staff with a wide range of training, the Assessment Team found that a lack of staff competence and knowledge meant care did not always meet consumers’ needs. This was noted in relation to knowledge about restrictive practice, pain management and using a CPAP machine. Evidence relevant to the finding includes:

* Generally, consumers said most staff perform their duties effectively, and they were confident that staff were trained appropriately and were skilled to meet their care needs. However, some consumers did not feel as confident that staff could deliver the care required.
* Two consumers experienced significant pain at night. These consumers were receiving analgesic medication under the care of the medical officer and clinical staff.
* Management said all staff were trained in medication management and have annual competencies. If there were any medication incidents staff involved do further education and competencies and are not permitted to administer medications until they have been assessed as competent.
* One consumer said that new staff did not have the knowledge to set up their positive continuous positive airway pressure machine at night.
* In response to the Assessment Team’s feedback, management immediately conducted education sessions for the new staff to ensure they were competent in using the CPAP machine.

The Approved Provider’s response acknowledged there were opportunities for improvement however, they refuted the finding of the Assessment Team that the Requirement was Not Met, based on the evidence presented. The Approved Provider submitted additional evidence of staff competence and a copy of new amendments to the service’s plan for continuous improvement which included actions related to training. The Approved Provider advised:

* Extensive ongoing education is provided to staff by the service. This includes mandatory needs-based training where gaps are identified.
* Training needs are regularly reviewed and updated by the service and a training calendar is developed and implemented.
* Training in use of the CPAP machine was provided to new staff at the time of the audit.
* The Management Team and Quality Team have identified further training needs including the management of CPAP machines and included actions on the continuous improvement plan to address these needs.

I acknowledge the service has reviewed the issues identified by the Assessment Team and has either, completed corrective actions during the audit, or included corrective actions to be undertaken on the service’s continuous improvement plan. I find it reasonable that new staff required, and were given, instruction in setting up a particular CPAP machine for a consumer. I note the management of pain in the specific consumers was under the current supervision of the medical officer and clinical staff had knowledge of pain monitoring practices. I do not attribute the challenges in delivering effective clinical care to individual consumers as general failure in the service’s approach to ensuring staff competence and training. I have considered these issues in Standard 3(3)(a) as I consider they relate to challenges in clinical care delivery associated with individual consumers with complex care needs.I find that the service’s workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

I find the service Compliant with this Requirement, based on the evidence summarised above.

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

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

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Compliant as 5 of the 5 specific requirements have been assessed as Compliant.

Overall, sampled consumers and their representatives said the organisation was well run and they could partner in improving the delivery of care and services. The service has established processes to support consumer engagement in the development, delivery and evaluation of care and services. ‎Consumers and representatives were involved in the development, delivery, and evaluation of services at the organisation through various means including; quarterly consumer meetings, biannual ad-hoc surveys, feedback and complaints and food and meals surveys. The monthly review of care plans also enabled consumers and their representatives to be actively engaged in the development of their care and service plan. This includes a goal-setting process for each consumer. Consumers and representatives confirmed they were comfortable contacting the service with any feedback and felt engaged in the delivery and evaluation of care and services.

Management advised there was a robust organisational structure governing the delivery of quality care and services. Central organisational policies and procedures promoted a culture of safe, inclusive, and quality care and services. The Board consisted of medically, clinically and legally trained members who were accountable for the organisational culture and performance. Board members regularly meet and visit the service in person. The organisation has a Medication Advisory Committee which meets quarterly and discusses medication incidents, antimicrobial stewardship, psychotropic medication usage and other clinical indicators. The clinical leaders and executive management report to the Board of Directors. The Board and its subcommittees ensure the service is meeting the Quality Standards and addressing issues as they arise. There is a monthly manager meeting which discusses quality and safety, legislation changes, policies and procedures, complaints trends and staffing. The service manager sends a monthly report as well as the clinical indicator report.

‎Management could describe changes driven by the Board in the previous 6 months as a result of consumer feedback, experience, and incidents. The service demonstrated it had implemented effective governance systems relating to the management of information, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints. The service provided a documented risk management framework, including policies describing how:

* ‎Managing high impact or high prevalence risks to consumers.
* ‎Abuse and neglect of consumers is identified and responded to.
* ‎Consumers are supported to live the best life they can.

Staff had been educated about these policies and were able to provide examples of relevance to their work. Management said there were monthly quality meetings where high prevalence incidents were discussed and preventative strategies were implemented. The quality team also review incident reports monthly, and any concerns were escalated to the Board.

‎Clinical staff demonstrated knowledge about the prevention of elder abuse and serious incident reporting, especially the reporting and escalation processes. The service has an incident reporting and investigation procedure that encourages quality and improvement within the service.

Management demonstrated that they have implemented a clinical governance framework that is understood by the service’s staff. The organisation provided:

* ‎A documented clinical governance framework.
* ‎A policy relating to antimicrobial stewardship.
* ‎A policy relating to minimising the use of restraint.
* ‎An open disclosure policy.

Staff had been educated about the policies and were able to provide examples of relevance to their work. Staff said when legislation changes were introduced, such as those for restrictive practices and serious incident reporting, education was provided to the staff. ‎‎Clinical staff were able to describe how the service minimises the use of restrictive practices and antibiotics to minimise the development of antimicrobial resistance. Management advised the open disclosure policy was updated in April 2022 and a training package was required to be completed by all staff.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

### Requirement 8(3)(d) Compliant

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

### Requirement 8(3)(e) Compliant

*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.*

# 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.

* Ensure that each consumer gets safe and effective personal and clinical care that is best practice, tailored to their needs and optimises their health and well-being.