Performance

Report

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| Name: | Uniting Eden |
| Commission ID: | 0842 |
| Address: | 22 Barclay Street, Eden, New South Wales, 2551 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 16 January 2024 to 18 January 2024 |
| Performance report date: | 19 February 2024 |
| Service included in this assessment: | Provider: 1352 The Uniting Church in Australia Property Trust (NSW)  Service: 6388 Uniting Eden |

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 Uniting Eden (**the service**) has been prepared by Therese Solomon, 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 Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 13 February 2024.
* Notice to Remedy Non-Compliance issued to the approved provider dated 24 February 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Applicable |
| **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 Applicable** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

Requirement 2(3)(e)

* Ensure incidents are consistently investigated, and care and services are reviewed after an incident or when consumer circumstances change, specifically related to pain management, wound management, skin management.
* Ensure 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.

Requirement 3(3)(d)

* Ensure 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, specifically related to pain management, skin management, palliative care and infection management.

# 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)(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)(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

Requirement 1(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated, and consumers and/or representatives confirmed, consumers are consistently treated with dignity and respect with their culture and diversity valued. Care planning documentation reflected the diversity of consumers, including information about their background, culture and religious beliefs and preferences. Staff were observed interacting with consumers respectfully and were familiar with consumer’s backgrounds. The service has policies that outline what it means to treat consumers with dignity and respect.

Requirement 1(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives described how consumers are supported to exercise choice and independence and maintain relationships that are important to them. Staff were able to describe how consumers are supported to make informed choices about their care and services, and how they support consumers to maintain relationships that are important to them. The organisation has policies in place supporting consumer choice, informed consent, and dignity of risk.

Requirement 1(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The Assessment Team observed information was available to consumers and/or representatives to support consumer’s decision making. The information available was clear and easy to understand and consumers described information they receive help them make decisions about the things they would like to do and eat, such as individual copies of monthly activity calendars, daily menu choices, as well as regular information updates from management about what is happening at the service. Staff were able to describe the different ways in which information is provided to consumers, including consumers with a cognitive deficit. The service provided evidence of choices being offered to consumers including catering, lifestyle preferences and recreational activities.

Consumer meetings are held monthly and include information about comments, complaints, food, continuous improvements, workplace health and safety, new and changed legislation, and how to give feedback and activities.

Requirement 1(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated there are processes in place to ensure each consumer’s privacy is respected and their information kept confidential. Consumers and/or representatives indicated staff maintain their privacy and dignity in personal care and keep their information secure. Staff demonstrated a sound knowledge of the importance of maintaining consumer confidentiality and how they maintain privacy and respect in all aspects of care.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

Requirement 2(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives stated they had been involved in planning their care, starting from entry to the service. Care planning documentation show consumers are assessed on entry to the service, and a care plan is developed to inform care.

Management advised an assessment approach to all areas of care and services is taken when consumers first enter the service which includes collaboration with the consumer, the representatives they want involved, homemakers, and care staff. Initial assessments are completed over the first seven days and used to provide information in the delivery of care, while comprehensive assessments are undertaken to develop the consumer's individualised care plan. Registered nurses described the assessment process, which includes following the new consumer checklist, and how it informs the delivery of safe and effective care and services.

The Assessment team reviewed consumer care plans, all of which demonstrated effective, comprehensive assessments and care planning processes to identify the needs, goals, and preferences, including identifying risks to each consumer's health and well-being. There is a care plan review tracker which was observed to have no care plans overdue for review.

The Assessment Team found care and services are not consistently reviewed on a regular basis for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer.

Clinical staff described the process of regular review of care and services for consumers after incidents or changes in condition occurred. Consumer care and planning documentation was noted to have been reviewed for some consumers when an incident or change impacted the care needs, goals, or preferences of the consumer but this did not occur consistently for all consumers. Consumers experiencing changes in relation to pain, wounds, pressure injury, and diabetic care did not consistently have their care and services reviewed for effectiveness.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found Non-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. | 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)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, tailored to their needs and optimises their health and well-being. Care documentation for consumers demonstrated individual preferences regarding personal and clinical care are documented, weight management plans have been reviewed and are current, and post fall reviews, monitoring and observations were attended.

Consumers and/or representatives provided positive feedback about the clinical care and staff practices regarding their care management, saying they had attended discussions about their care planning, saw the medical officer or other health providers as they needed and were generally satisfied with care. Consumer representatives stated they receive regular updates for care plans, and if unable to attend a review, can read and comment on care plans which are emailed to them.

The service has several consumers at risk of malnutrition, or who have experienced or are at risk of weight loss. Records show weight is regularly monitored and those consumers identified as having lost weight are followed up with further investigations including food and fluid intake monitoring, referral to the medical officer, dietitian, and speech pathology reviews. Nutritional assessments, dietary preferences, and additional nutrition supplements were also noted.

Consumer records and behaviour support plans show review and recommendations from Dementia Support Australia, older persons mental health, and medical specialists in addition to the medical officer. Documents also demonstrate consumers prescribed psychotropic medications and restrictive practices are reviewed at 3-month intervals. Care staff described consumer behaviours of concern and strategies implemented to manage these.

The Assessment Team identified areas for improvement in relation to the effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team noted that for consumers who are identified as a high falls risk and experienced multiple falls, their files showed appropriate reviews and fall management plans in place. Strategies recommended by the physiotherapist are used to prevent falls or reduce the risk of falls, including exercise programs to improve strength and mobility, staff supervision and assistance with daily activities as well as the use of mobility devices. The effectiveness or ineffectiveness of these strategies is observed documented in consumer files.

Staff completed the required observations according to the service's post falls directive, and when appropriate, a review is conducted by both the medical officer and the physiotherapy team, and if required consumers are transferred to hospital for further review and management. Staff stated other actions were to ensure consumer rooms were tidy and minimise hazards such as power cords around consumer beds, clear access to bathrooms, call bells nearby and regular continence rounds.

Skin integrity assessments and checks are attended on admission, during the monthly resident of the day processes, and during routine care delivery. Consumer care plans note interventions to minimise deterioration of skin integrity and pressure injuries for consumers. These include regular toileting schedules, repositioning and use of pressure relieving devices when necessary, maintaining mobility and function as much as possible, skin moisturisers, and attending to nutrition and hydration needs.

Wound care charts are commenced when wounds are identified, and referrals made to the medical officer, wound care consultants or other designated staff, for complex or non-healing wounds. However, the Assessment Team identified wound care charting documentation was inconsistent at times, with wound changes not always completed as per the plan, and photographs are not routinely taken at dressing changes. Management stated photographs were to be taken monthly as a minimum.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found Compliant.

The service did not demonstrate that clinical changes or deterioration in consumers condition is always recognised and responded to in a timely manner. The Assessment Team identified incidents where deterioration or changes in consumer condition was not recognised and actioned in a timely manner resulting in negative outcomes for consumers, specifically in relation to infection management, pain management, palliative care management and skin integrity management.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(d) is found Non-compliant.

Requirement 3(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated it has procedures in place to ensure currency and accuracy of information regarding consumers and their care and services.

Consumers and/or representatives were satisfied with their care and services, and considered it met their needs. Consumers recalled being involved in discussions about their care or preferences, and receiving, or being offered their care plans.

Consumer representatives stated they were satisfied the service communicates with them regularly, and they are kept up to date with their consumer’s current care, any concerns, incidents, or changes that occur. Consumers and/or representatives recalled discussions about care needs, or frequently receiving copies of care plans, in addition to other communications relating to consumer care and services.

The Assessment Team observed information related to external service providers documented in consumer care and service plans.

Requirement 3(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that it has processes in place to guide referrals to other organisations or health care providers where consumers require these services. Consumer records and documents evidence referrals and consultations from a variety of other health services and providers including Dementia Services Australia, allied health professionals, medical officers and specialists with recommendations discussed and included into the care plan for the consumers.

# 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)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement 4(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated each consumer gets safe and effective services that meet their needs, goals and preferences and optimise their independence, health, well-being, and quality of life. Consumers and/or representatives provided mostly positive feedback about their satisfaction with living at the service. Consumers and/or representatives stated they could choose to attend a large group activity or choose to enjoy their own activities independently. Consumer preferences are assessed, and a lifestyle care plan is developed for each consumer.

The Assessment Team interviewed well-being and lifestyle coordinators. The team are responsible for planning the activities calendar in conjunction with the home makers of the service. The well-being team provided evidence of consumer engagement and the process of ensuring activities for consumers are meaningful and regularly reviewed.

Requirement 4(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The Assessment Team observed meals provided at the service to be varied, nutritious and of sufficient quantity. Consumers and/or representatives provided positive feedback and stated they were mostly happy with the meals, snacks and drinks provided at the service.

Management advised the menu is seasonal and provided examples of how the menu can be changed to incorporate consumer feedback. Feedback is obtained through food focus groups, consumer meetings, surveys, and informal discussions with consumers and/or their representatives. Catering staff detailed how they receive information about new consumers or any changes in consumers’ dietary needs and were able to provide examples of consumer’s likes and dislikes, diet types, allergies, and intolerances and how they access this information each day.

Menus are assessed and require approval by the dietician prior to finalisation and implementation at the service. The service demonstrated incorporating the household model into food preparation including flexible breakfast times and options for alternative food for main meals. Tea and coffee, water and snacks were available to consumers and the Assessment Team observed staff making hot drinks for the consumers, offering a snack in between meals, and offering them alternative options for meals.

Requirement 4(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives indicated they felt safe using the service’s equipment, while feedback from management and staff as well as observations by the Assessment Team indicate equipment is safe, suitable, and clean. The service employs a full-time maintenance coordinator and has a 24 hour on call maintenance service available for emergencies and after hour requests. Consumers and/or representatives stated they were comfortable raising issues if equipment needed repair, knew the process for reporting an issue and said items were replaced when necessary.

Staff stated they have sufficient and suitable equipment to enable them to effectively attend their work and to support consumer participation and independence. This includes lifters, hoists, ceiling hoists, princess chairs and mobility aids and a newly purchased shower chair. Staff indicated if there are issues with the equipment, they report this to maintenance, and if necessary, maintenance report to management and discuss opportunities for replacement or repair. The maintenance manager stated communication between staff is conducted by an online register and he is aware of any equipment that needs maintenance or replacement.

# Standard 5

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| Organisation’s service environment | |  |
| 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 |

Findings

Requirement 5(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The Assessment Team noted the service looked clean, safe, and well maintained, including several dining rooms, lounges, games room, movie theatre and large areas for group gatherings. All rooms are single rooms with an ensuite, and all rooms looked well maintained and comfortable. The service had several garden areas that were tidy and maintained. Consumers were able to access outdoor areas freely and doors leading to the outside were not locked and easily opened.

The Assessment Team interviewed cleaning staff who showed a comprehensive cleaning schedule for consumer rooms, common areas, high touch areas and bathrooms. The cleaning schedule included daily, weekly, and monthly tasks and cleaners are at the service seven days a week. The cleaning schedule follows the household model which promotes consumers having the option to be independent with cleaning if desired and offers assistance for ensuring rooms and bathrooms are clean, safe, and well maintained. Consumers and/or representatives consider the service environment to be safe, clean, well maintained and enables them to move freely both indoors and outdoors.

# Standard 6

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

Findings

Requirement 6(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that consumers, their family, friends, carers, and others are encouraged and supported to provide feedback and make complaints. The Assessment Team observed brochures and posters on display around the service environment, including but not limited to how to raise a concern or a complaint, and translator and interpreter services. Information included both internal and external avenues available to consumers and others to raise complaints.

The consumer newsletter includes information about complaint themes raised in consumer meetings, as well as further information regarding how to raise a concern or complaint. Contact details for Older Person’s Advocacy Network and the Commission’s complaint service are included in the newsletters. Consumers stated there is lots of feedback and discussion about the food and menu and there is a regular food meeting where they can have their say about menu planning and food. Notices and schedules for the food focus group and consumer meetings were seen on notice boards around the service.

Requirement 6(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representative felt they were satisfied with their service and care. Most consumers stated they would speak directly to staff or management about any concerns they had, or they would tell their family or representative who would follow up any complaints or concerns should they have any. Consumers felt confident any concerns they raised would be dealt with by the service management, and they would not need to use alternative services.

The Assessment Team observed contact details for Older Person’s Advocacy Network and the Commission’s complaint service are included in the newsletters and noted information on display related to accessing translator and interpreter services.

Requirement 6(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated there are processes in place to record and follow up complaints, and an open disclosure process is implemented when dealing with complaints.

Staff complete online learning about the complaints process, and open disclosure. Staff demonstrated an understanding of open disclosure and were able to describe how this relates to their role.

Management described the process followed in handling complaints, and provided evidence to demonstrate actions taken, including but not limited to sending a letter of acknowledgement of the complaint with the offer of a meeting to discuss the matter more fully, having a meeting to discuss concerns and offering an apology. The service will also send a follow up letter which includes issues covered, apology and areas for improvement resulting from the complaint.

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that feedback and complaints are reviewed and used to improve the quality of care and services. The service provides information regarding complaints, and actions taken to consumers and/or representative in the regular newsletters, letters, emails, and meetings. Consumers and/or representatives did not raise any concerns regarding complaints or areas for improvement at the service. Consumers advised there are regular meetings about food and the menu and consumer meetings where they can have their say if they want, and concerns are discussed.

The current plan for continuous improvement was sighted, which included feedback and actions taken in response to consumer feedback. Management stated in regard to consumer driven improvements, the outdoor furnishings had been replaced following comments and feedback about having meals outside at times. Consumers were observed using the outdoor seating and dining area in one household and enjoying the outdoor setting.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service effectively demonstrated the workforce is planned to enable the delivery and management of safe and quality care and services. The number and skills mix of staff is maintained and managed effectively and there is an ongoing recruitment process to increase clinical and care staff. Management could demonstrate a recruitment process to attract new care and clinical staff to the service.

Management advised the process of covering unplanned leave which included offering overtime or additional shifts to staff, extending hours of shifts, utilising agency staff and occasionally utilising other suitably qualified staff members such as administration or lifestyle coordinators. Clinical and care staff stated they work as a team and feel supported to escalate any concerns to clinical staff or management.

Consumers and/or representatives stated staff are providing safe and quality care and confirmed they are satisfied with the staffing levels, and the call bells are answered in a reasonable time.

Requirement 7(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives expressed satisfaction with staff interactions, stating that staff are kind, caring and respectful in relation to their identity and diversity. Staff were observed engaging with consumers and representatives in a kind and respectful manner. Care planning documentation is individualised and includes the cultural and personal preferences of each consumer at the service.

Requirement 7(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated a comprehensive orientation package for internal and agency staff. The orientation process for includes access to policies, online education and the electronic management system, buddy shifts, introduction to staff and consumers and information about the code of conduct and Uniting values.

The orientation program includes competencies such as hand hygiene, personal protective equipment and manual handling including use of lifters, hoists, and slide sheets. The care coach could describe the orientation process including training and signing off competencies for new staff. Care staff confirmed this process was well structured and they felt supported through this.

The service demonstrated they have documented position descriptions and qualification checks for all staff including certificates, medication qualifications and relevant registrations. Consumers and/or representatives felt that staff have the qualifications, knowledge, and skills to meet their clinical and personal care needs.

Requirement 7(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated the workforce is trained, equipped, and supported to provide safe and effective clinical and personal care to each consumer. Several staff confirmed attendance and completion of training including topics such as Serious Incident Response Scheme, restrictive practices, infection control, and specialised care topics.

Staff employed at the service have mandatory training on commencement of their role and thereafter every twelve months, which was evidenced through training records. The mandatory annual training includes emergency training, manual handling, code of conduct, hand hygiene and Serious Incident Response Scheme identification and reporting requirements. The information is kept on a spreadsheet and on an electronic training system, and the service manager has responsibility to oversee all training is current. The service provided evidence that all mandatory training is current and up to date for all staff.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated assessment, monitoring and review of the performance of each member of the workforce is undertaken. Staff confirmed they have undertaken a performance appraisal process and have been provided with notice before undertaking the formal process with management. Staff stated they received regular training and areas for further development are discussed at the performance appraisal process and staff feel supported through this process.

Management advised that feedback about staff performance is captured in different ways, through audits, consumer and representative feedback, staff feedback and observations. Management explained the service’s disciplinary process and stated policies and procedures are available to guide management through performance management processes where required. Management provided evidence of a formal performance review of a senior staff member for underperformance.

# Standard 8

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

Findings

Requirement 8(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

There is an organisational-wide approach to involving consumers and/or representatives in the development and delivery of care and services to ensure they are consumer-centred. All consumers and representatives interviewed said they felt included and encouraged to provide input into decisions made at the service, and felt the service was well run.

The organisation has effective systems in place to gather feedback from consumers and/or others, and then to act on the feedback. Management advised the organisation is proactive in including consumers in any change to their environment, such as their input to the purchase of new furniture.

Audits and surveys are regularly undertaken with consumers and/or representatives to ascertain their views and feedback on care and services. This includes management regularly having a meal with consumers as part of their monthly governance oversight to check on the quality of meals and the dining experience.

Requirement 8(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has a strategic plan which outlines how it will ensure safe and inclusive care for consumers. The governing body’s approach to a culture of safe and inclusive quality care is reliant on receiving regular communications and reports through its sub-committees. It has identified key areas of focus in order to identify, assess and take action to improve safety and ensure effective care delivery for consumers. A single set of indicators has been developed which are shared from the board to service level, ensuring there is a common way for the service and the board to discuss care and safety performance.

Management advised the Board is accountable and satisfies itself that the Quality Standards are being met within the service through the reporting structures of the organisation. This involves the collection and analysis of data at a local and organisational level and includes key performance indicators, clinical data, feedback and complaints, incidents, high-impact and high-prevalence risks, recruitment, staffing/rostering, continuous improvements, quality indicators, auditing results, surveys, and education.

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has effective organisation-wide governance systems in the key areas of information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. It was demonstrated these are effective at the service level within the organisational governance framework and accountability structure.

The organisation has information management systems including electronic care management system, risk/incident management, compliance, complaints, maintenance, education/training and human resources. Reports and data are generated from these systems for analysis and review by staff and are considered in scheduled and structured meetings. Management advised most systems are now electronic and relevant information including areas of risk to consumers, is escalated as necessary to the governing body.

Management advised they have all the resources they need for the delivery of care and services and provided an overview of its financial governance arrangements. At the service level, appropriate programs are in place for the maintenance and renewal of the service, including restoration, repair, replacement, extension and renovation of the facilities and equipment. Management has discretion for out of budget expenses within policy limits and confirmed all requests to date have been granted. Management provided evidence of the purchase of items based on consumer requests.

The organisation monitors changes to aged care regulation and legislation via its subscription to a peak body and through its audit and risk framework. There are associated processes for when legislation changes, whereby the policy review steering committee updates, develops and oversees the implementation of new and changed policies. The organisation provides the service’s management team with regular updates on any legislative and policy changes and any new or updated organisational policies and procedures at regular management meetings. Relevant communications and training are provided to staff in relation to changes and new requirements, and there are governance and system processes to ensure this occurs.

The organisation has a risk management framework, which underpins its risk management strategies, and this includes a risk matrix for determining the level of risk, sets out responsibilities, and includes policies and procedures. The risk management system is monitored at a local level by the management team through clinical assessment, daily review and ongoing monitoring, collection and analysis of clinical data, and audits. Oversight is provided at an organisational level through a process of audits, reporting and escalation through committees. Trends and areas for improvement are identified and acted on.

The organisation has policies relating to the dignity of risk and consumer choice and decision making. Where a consumer chooses an activity or to live an aspect of their life in their own way which involves some risk, the service uses a risk consultation process to assess the risk and discuss with the consumer how they can best be supported.

The organisation has an incident management framework which includes policy, procedures and guidance on mandatory reporting responsibilities, management and closure of incidents, open disclosure, roles and responsibilities, safety and support, clinical governance and continuous improvement, and related flowcharts.

Management reported all incidents and hazards are entered into the electronic risk management system and all Serious Incident Response Scheme incidents and level one incidents are escalated and reviewed at board level. All incidents are analysed to determine the cause and ensure prevention strategies are put in place where required. Staff advised, and training records corroborate, they have received training in recognising and responding to abuse and neglect of consumers, Serious Incident Response Scheme, and incident management.

However, the Assessment Team identified the risk management systems and practices did not always identify and respond to abuse and neglect of consumers. Management did not follow the organisational policy related to incident management, resulting in negative outcomes for a consumer.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(d) is found Compliant.

Requirement 8(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated it has a clinical governance framework which includes policies and procedures, responsibilities, planning, monitoring and improvement mechanisms that are implemented to support safe and quality clinical care. Management advised clinical care starts with consumer partnership and engagement to define their care and is managed and monitored at a local level by the service’s clinical leadership team. Clinical care is further supported by other organisational clinical mechanisms including the specialised regional quality teams, specialist clinical roles, the medication advisory committee, and the ageing clinical governance committee.

The organisation has an antimicrobial stewardship policy and procedure. Infections are monitored, and antimicrobial stewardship is discussed at clinical and medication advisory committee meetings. Staff confirmed, and training records indicate, they have received training in antimicrobial stewardship aligned to the Quality Standards and internal policy guidelines. Some staff were able to explain how they promote optimal management of antimicrobials in order to maximise the effectiveness of treatment and minimise the potential for harm.

The organisation has an open disclosure policy and training records evidenced staff have received training. Staff were able to describe open disclosure processes and principles in relation to their role, and feedback from consumers and/or representatives confirmed open disclosure is practised in the service when incidents or adverse events occur.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)