Performance

Report

**1800 951 822**

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| Name of service: | Uniting Elanora Shellharbour |
| Service address: | 7-23 Wallaroo Drive Shellharbour City Centre NSW 2529 |
| Commission ID: | 0969 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 August 2023 to 2 August 2023 |
| Performance report date: | 26 September 2023 |

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 Elanora Shellharbour (**the service**) has been prepared by J Durston, 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 - Site; the Assessment Contact - 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 23 August 2023

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-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.

* Ensure wounds and pressure injuries are regularly checked, treated and dressings changed in line with the consumer’s care plan.
* Ensure wound charts are current and reflect all of the consumer’s wounds.
* Pain assessments are to be completed when required, ongoing monitoring evaluation and review of effectiveness of pain management to be undertaken, and pain is to be considered during the provision of wound care.
* Risk assessment in relation to self-administration of medication to be completed if a consumer’s physical or cognitive condition deteriorates.
* Continue to monitor and provide education to staff in the correct use of PPE, knowledge and understanding of infection control protocols and antimicrobial stewardship.
* Continue to monitor and provide education to kitchen staff in the correct use of hairnets while preparing food in relation to infection control.
* Continue to regularly review and reduce incidence of polypharmacy at the service.
* Evaluate and review the organisation’s risk governance system, accountabilities and structure to improve identification, effective management and prevention of all high impact, high prevalence risks to consumers and to recognise risk trends in a timely manner.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |

Findings

The service was found non-compliant in Requirement 1(3)(b) following a site audit from 31 May to 2 June 2022. The service did not demonstrate care and services were culturally safe. Some consumers reported difficulty communicating requests and care needs to staff who needed to source a Spanish speaking colleague to understand them. Other consumers described requiring assistance to read menus that were only offered in English.

An Assessment Contact was conducted on 1 August to 2 August 2023. The Assessment Team found the service has implemented improvements in response to the non-compliance raised in the 2022 Site Audit. The service’s menus and activity schedules have been translated into multiple languages, and communication cue cards have been created for staff to use to assist their communication with consumers.

During the Assessment Contact the Assessment Team found all sampled consumers and representatives said staff know consumers’ cultural backgrounds well and respect their needs and preferences. All staff were aware of the cultural diversity of consumers at the service and provided examples of how they deliver culturally safe care, particularly around communicating with consumers where English is their second language. Staff have a translation device provided by a specialist dementia service and access to the government translation service. Consumers’ care planning documentation contained information about their cultural needs and preferences.

Accordingly, I find Requirement 1(3)(b) is 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. | Non-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)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

The service was found non-compliant in Requirements (3)(a) and 3(3)(b) following a site audit from 31 May to 2 June 2022. Regarding Requirement 3(3)(a) The service did not provide safe, effective and best practice personal and/or clinical care that met the needs of sampled consumers, as gaps were identified in pain management, falls management, wound management, diabetes management and psychotropic medications. Regarding Requirement 3(3)(b), the service did not effectively manage high impact high prevalence risks associated with the care of each consumer. Deficiencies were identified with falls management, wound management, medication management including polypharmacy, and risk assessments for the use of electric wheelchairs.

Requirement 3(3)(a)

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement, including a review of care plans aligned to governance processes, case conferences held with representatives identified in the 2022 site audit, delivery of education on documentation and management of diabetes and management of wounds, psychotropic medications and pain.

The Assessment Team found care and service documentation showed that the service is effectively managing the care of consumers subject to restrictive practices. The consumers who previously mobilised using electric wheelchairs no longer have the capacity to use them. However, observations and a review of care and service documentation showed some deficiencies previously identified during the Site Audit in 2022, in the areas of wound management, falls management, pain management, and diabetes management were ongoing.

The Assessment Team found consumers identified with chronic wounds and/or pressure injuries were referred to a wound specialist. However, care and service documentation showed wounds and pressure injuries were not being regularly checked or dressings changed in line with the consumer’s care plan. The wound chart for one named consumer’s showed the required 2 daily dressing change for their wounds had not occurred for 5 to 6 days and one wound was infected with a multi-resistant bacteria. The wound dressing for the toe of one consumer was also not changed for 5 days and the toe was noted to be necrotic at the time of the Assessment Contact. Wound charts and care plans for some consumers were noted to be outdated, inconsistent or conflicting, including photographs of multiple wounds for one consumer, with the wound chart identifying only 1 out of 3 wounds on the same leg, lack of repositioning charts and the required frequency of repositioning was not recorded in the care plan of another consumer.

In their response to the Assessment Team report, the approved provider disputed the findings of the Assessment Team in relation to wound management. The approved provider advised that all consumers’ current wounds have continued to heal, were escalated to the service’s clinical nurse consultant and the organisation’s regional clinical nurse consultant for wound management through automated emails generated by the electronic wound data base. The organisation has additional wound management specialists/leads who can assist if required. The approved provider disagreed with the Assessment Team’s findings that a named consumer had multiple wounds without the required 2 daily dressing changes. They advised that there was only one dressing not changed within the time frame and there were ‘no adverse effects for the consumer.’ The approved provider noted that the consumer with the necrotic toe was reviewed by the podiatrist 2 weeks after the wound was identified and a plan was outlined for daily dressings.

The approved provider acknowledged separate wound charts were not in place for multiple wounds of one consumer for treatment and monitoring, but stated this did not have any adverse clinical impact for the consumer, and the consumer now has separate wound charts for each wound. The approved provider also noted that the service’s procedure for documenting repositioning of consumers for pressure area care is done by exception in progress notes, rather than charting each time repositioning is attended, and repositioning instructions have been added to the care plan of one named consumer. The approved provider disputed the Assessment Team’s finding that there was conflicting information on a named consumer’s wound chart as to whether a wound was active or inactive on a specified date.

The Assessment Team found pain assessments are not being undertaken when required. Pain is not being considered during the provision of wound care. Review of care and service documentation showed some consumers did not have appropriate non-pharmacological pain management strategies used, nor evaluation of those strategies attended. One consumer had non-pharmacological strategies listed but these were not considered appropriate by the Assessment Team, such as provision of warm milk. Evaluations of pain management strategies implemented were not documented. Management said a full review of pain management care plans occurred after the 2022 Site Audit, but they would conduct another review and provide education to staff. However, the Assessment Team found for the consumer whose toe became necrotic, a pain chart to monitor pain was not commenced until they were reviewed by the medical officer two days after the wound was identified and pain relief was charted for breakthrough pain.

In their response to the Assessment Team report, the approved provider advised that clinical documentation demonstrates evidence that pain is considered during wound dressing changes. This was recorded in one consumer’s care plan supplied in evidence by the approved provider, but there was no documented evidence provided that pain was actually considered. The approved provider stated a review of pain management of all consumers was conducted in consultation with consumers and representatives following the June 2022 site audit, and currently all consumers’ pain management is effective with no concerns raised by consumers or their representatives. However, the approved provider acknowledged that the delayed pain charting for the consumer whose toe became necrotic was not in line with their procedures. The approved provider disputed the Assessment Team’s finding that some non-pharmacological pain management strategies were not appropriate, and advised that the provision of a warm drink used with relaxing music by a named consumer helped them to relax to assist with their pain management.

The Assessment Team found the psychotropic register was up to date. However, some consumers had no diagnosis listed for their psychotropic medication, and several consumers had a diagnosis listed that is not recognised for the medication prescribed, such as antidepressant medication prescribed to treat behavioural and psychological symptoms of dementia (BPSD). Some medication review periods were outside the organisation’s policy of 3 months. However, during the Assessment Contact management said the medical officer reviews medications on a weekly basis and the register would be updated.

In their response to the Assessment Team report, the approved provider advised that the psychotropic self-assessment (register) has been updated to reflect the current prescribed medications for the named consumers. The approved provider noted a named consumer who had BPSD listed as the diagnosis for the use of an antidepressant medication has a diagnosis of depression/mood affective disorder that is recognised for the prescribed medication, and the register has been updated with the correct information.

The Assessment Team found that care and service documentation for consumers who have diabetes mellitus showed consumers did not always have a diabetic management plan or their diabetes management plan was not followed. Sampled consumers’ diabetic management plans contained generic information and lacked goals and preferences or strategies to manage blood glucose levels out of range. Management acknowledged that their existing recording of instructions on medication charts were not diabetes management plans. They were prescriptions for as needed (prn) insulin and when it should be given.

In their response to the Assessment Team report, the approved provider advised that general practitioners treating consumers with diabetes have been notified to complete their general practitioner directive for diabetes management plan, instead of the previous practice of documenting directives in progress notes and medication charts, to ensure diabetes management plans are readily available.

The Assessment Team found that medication documentation and representative interviews showed deficiencies in risk management in relation to self-administration of medications. While recovering from COVID-19, a named consumer who appeared confused and unable to administer their medication, missed administering their insulin dose, and was not promptly reassessed for their self-administration capacity. Also, the consumer was not given a dose of their antiviral medication for treatment of COVID-19. The incident report did not include strategies to prevent the incident from reoccurring. The Assessment Team noted the consumer’s representative confirmed the service had informed them of the incidents, and expressed they were not concerned as there appeared to be no impact on the consumer’s wellbeing.

In their response to the Assessment Team report, the approved provider advised the correct organisational procedure was followed in relation to the consumer’s missed insulin dose. The service was unsuccessful in contacting the medical officer, but the incident was escalated to the registered nurse discussed and offered the insulin to the consumer, who declined. The consumer’s representative was contacted and advised the service was to follow the consumer’s wishes. The approved provider also confirmed the incident did not negatively impact the consumer, whose blood glucose levels remained within range on the day the insulin was missed.

I acknowledge the actions taken by the approved provider to rectify issues identified by the Assessment Team in relation to this requirement, and the detailed plans for continuous improvement covering the care of named consumers and the deficiencies identified by the Assessment Team. I note that in a number of areas the approved provider and/or the Assessment Team identified there was no significant negative impact to consumer’s health, safety and wellbeing resulting from incidents in relation to medication management and diabetes management. However, I do not consider the service’s wound and pain management processes have been consistently effective with regard to pain monitoring, charting and evaluation, timely and effective wound dressing, treatment, monitoring and review, despite the improvements implemented by the service after the 2022 site audit, the availability of specialist inhouse organisational wound consultants and actions taken since the Assessment Contact. Deficiencies in these areas of care posed a significant risk to and had a significant negative impact on the health, safety, wellbeing and quality of life for some consumers. I understand that it will take some time to reflect compliance with this requirement to ensure the improvements are sustained.

Accordingly, I find requirement 3(3)(a) non-compliant.

Requirement 3(3)(b)

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement, including monthly clinical data reviews, updating the risk register, monthly ‘continuous conversations’, providing ongoing review and education to staff. Education was provided in relation to falls management, wound management, use of electric wheelchairs, weekly medication reviews, use of single use bottles of fluid thickener.

During the Assessment Contact, the Assessment Team found consumer and representative feedback regarding management of high impact high prevalent risks was mostly positive and staff knowledge around consumer care needs was sound. However, observations and care and service documentation showed the gaps previously identified during the Site Audit in 2022, in falls management and wound management are ongoing.

Care and service documentation showed post falls management was not being attended as per the organisation’s policies, procedures and best practice. Post fall vital signs and neurological observations were not attended for several consumers. Comprehensive incident root cause analysis was not done to determine preventive strategies for consumers who had multiple falls with negative impacts, including hospitalisation for one named consumer after sustaining a fracture. The consumer had been identified as a high falls risk on admission to the service, and had multiple falls associated with self-toileting. This was recorded in progress notes on several occasions leading up to their injury. A toileting schedule was recommended to address the risk but not implemented. Also, incident reports for 2 of the consumer’s falls did not contain full investigations into the cause of each incident and strategies to be put in place to prevent the falls risk.

In their response to the Assessment Team report, the approved provider referred to the service’s strengthened multi-level clinical governance system, including weekly resident risk and safety meeting. The approved provider described the falls assessment process including identification of consumers with a high falls risk on admission. For the named consumer the approved provider supplied evidence, including a mobility care plan, physiotherapy assessment and exercise program to mitigate their falls risk. The approved provider advised the service has since completed their 28-day assessment process with the consumer after they returned from hospital. The consumer has decided not to follow a recommended strategy to reduce their risk of falls while attending the toilet unassisted and a positive risk assessment has been attended. The approved provider also noted that from the first night at the service an out of bed alarm was in situ to alert staff if the consumer required assistance to use the toilet. The consumer had made the decision not to have a toileting schedule because it was important to him to maintain his independence.

The service’s wound report showed there is a high prevalence of wounds. Review of care and service documentation for consumers with wounds and pressure injuries showed these were not being managed appropriately with negative impacts including wound infection. This was dealt with in Requirement 3(3)(a).

The service’s polypharmacy report for July 2023 showed a continued high prevalence of polypharmacy, with 8 consumers prescribed 20 or more medications. Management said they had identified this as a high prevalence risk and had done significant work to reduce the number of medications including regular medication reviews by the medical officer (evidenced in care and service documentation) with a view to ceasing some medications.

I acknowledge the risk identified by the Assessment Team regarding incomplete incident documentation including a lack of recorded incident causation analysis and prevention strategies following multiple falls incidents and serious injury sustained by a consumer. I consider the additional supporting evidence supplied by the approved provider regarding this issue and the detailed plan for continuous improvement to be more compelling in relation to compliance for this requirement. Particularly regarding the falls prevention strategies the service implemented from a named consumer’s first night at the service and the context of supporting the consumer’s documented preference to remain independent, and their decision not to adopt various falls prevention strategies recommended by the service both before and after their injury. I note that the approved provider has made significant progress in reducing polypharmacy and the number of consumers impacted are decreasing. I also note that high impact high prevalence risks associated with falls, wound and pressure injury management are dealt with in Requirement 3(3)(a)

Accordingly, I find requirement 3(3)(b) compliant.

Requirement 3(3)(g)

Following the 2022 Site Audit, the service was found compliant in Requirement 3(3)(g). However, during the Assessment Contact 0n 1 August to 2 August 2023 the scope of the Assessment Contact was extended to include this requirement because the Assessment Team observed significant non-compliance with the minimisation of infection-related risks and practices to promote appropriate antibiotic prescribing.

The service has systems in place to manage an outbreak and minimise infection related risks. However, practices to minimise the spread of infection minimisation and to ensure appropriate prescribing and usage of antibiotics were not always followed. Staff were observed breaching infection control protocols. Staff knowledge around infection control and antimicrobial stewardship was not adequate. The Assessment Team observed staff wearing personal protective equipment (PPE), such as face masks, warn below the nose incorrectly in care and dining areas, and a waste bin observed overflowing with used face masks. Several sanitizer stations were observed to be empty and not refilled during the visit. Staff were observed not wearing appropriate hair nets whilst preparing and serving meals in the servery. One consumer who had COVID-19 during the visit was not given their morning dose of COVID-19 anti-viral medication.

The Assessment team requested to see the service’s antimicrobial stewardship policy, but it was not provided. Progress notes for one consumer showed they were commenced on PRN (when required) antibiotics for a suspected urinary tract infection (UTI) without pathology being taken and escalation to the medical officer. Management acknowledged this was not best practice, but stated the medical officer had ordered the PRN antibiotics to be use at the consumer showed signs of a UTI because of their history of UTIs. Management informed the Assessment Team they had implemented formal and informal response strategies during the visit to address the issues raised, such as informal toolbox talks and allocation of online training on infection control to staff.

In their response to the Assessment Team report, the service advised a reminder memo was sent to staff on 1 August regarding the correct way to wear face masks, 87% of staff had their competency attended for personal protective equipment and hand hygiene and that this is a ‘work in progress. Administrative staff conduct daily checks on the floor. The service will conduct training on antimicrobial stewardship. Cleaning staff were informed to check and refill sanitiser stations. The service received an ‘A’ rating by the food authority of NSW in their August 2023 audit, and that it was found compliant in relation to wearing hair nets that are only required while preparing food.

I have considered the provider’s response and the actions it has taken and its plan for continuous improvement. However, I have placed more weight on the observations identified in the Assessment Contact report, that show despite the actions the provider has taken to minimise infection related risks, multiple examples of incorrect PPE use by staff, unfilled sanitiser stations, inadequate knowledge and understanding of infection control protocols and antimicrobial stewardship demonstrated by staff, and kitchen staff observed not wearing hairnets while preparing food (that the provider confirmed was a food safety compliance requirement), significantly increased infection related risks to consumers.

Accordingly, I find requirement 3(3)(g) non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The service was found non-compliant in Requirement 4(3)(f) following a site audit from 31 May to 2 June 2022. The service did not demonstrate that the food was of a suitable quality.

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement, including reintroduction of regular food focus groups, feedback cards were placed in consumer dining areas and clear instructions were provided to staff on heating and presenting food.

During the Assessment Contact the Assessment Team found most sampled consumers advised the service provides meals of suitable quality. Some consumers/representatives noted the dining area can be quite noisy and the Assessment Team observed staff using a handheld blender that could be heard across the dining room. in the kitchen Management provided examples of changes made in response to consumer feedback at food focus group meetings. Clinical staff described the admission process where they gather information on consumers dietary needs and preferences. All staff said they were aware of consumer’s dietary needs and preferences through care plans and information included in folders located in kitchens. Staff said they were informed of any changes to dietary needs and preferences through handover.

Accordingly, I find requirement 4(3)(f) compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

The service was found non-compliant in Requirement 6(3)(c) following a site audit from 31 May to 2 June 2022. The service’s complaints management system did not consistently capture all sources of feedback and complaints. Some consumers and representatives expressed dissatisfaction with the service’s lack of response to complaints. Most staff did not demonstrate an understanding of open disclosure and an open disclosure process was not consistently used.

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement, including the delivery of staff education sessions on open disclosure and a new system to improve complaint response times including acknowledgement within 24 hours and resolution with 7 days.

The Assessment Team found the service did not demonstrate appropriate action is taken in response complaints. Feedback from some sampled consumers and representatives was that staff immediately respond to concerns but they did not trust management would respond in a timely and appropriate manner. However, consumer survey results from April to June 2023 showed that approximately 50% of surveyed consumers felt the service would always take appropriate action if they made a complaint, approximately 40% felt the service would mostly take appropriate action and around 6% felt the service would sometimes or rarely take appropriate action. Nine staff were interviewed and all were able to explain how open disclosure applied to their role, and said they had recently received a toolbox talk on open disclosure. This was consistent with training documentation reviewed.

In response to the Assessment Team report, the approved provider supplied a list of policies and procedures related to feedback and complaints management and open disclosure. The provider supplied examples regarding how the service has followed up with multiple named consumers to resolve their concerns. A detailed plan for continuous improvement that addresses the identified deficits was supplied in the approved provider’s response.

I acknowledge the findings of the Assessment Team. However, I note that the April to June 2023 survey findings referred to in the Assessment Team Report showed that 90% of consumers surveyed felt the service would either always or mostly take appropriate action if they made a complaint. Having considered the improvements implemented by the approved provider and relevant actions in their detailed plan for continuous improvement, I find the approved provider’s response to be more compelling in relation to compliance with this requirement.

Accordingly, I find requirement 6(3)(c) compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(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

The service was found non-compliant in Requirements 7(3)(a), 7(3)(d) and 7(3)(e) following a site audit from 31 May to 2 June 2022. Regarding Requirement (7)(3)(a) the service was unable to demonstrate that they were providing a workforce that is planned to enable the delivery and management of safe and quality care and services. Regarding Requirement 7(3)(d) the service did not demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Regarding Requirement 7(3)(e) the service did not demonstrate that there is regular assessment, monitoring and review of the performance of each member of the workforce. An Assessment Contact was conducted on 1 August to 2 August 2023. The Assessment Team recommended that each of the requirements were met.

Requirement 7(3)(a)

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement, including increased availability of clinical nurse specialist to 7 days per week, implementation of a new roster management system that includes pre shift staff temperature check information, and messaging system to provide staff with more timely alerts about vacant shifts. There has also been a roster review to better meet permanent staff preferences, and consumer needs. There is now a quality coordinator permanently located at the service and an educator ‘care coach’ 10 days per week including weekends, morning and afternoon shifts. A uniting clinical nurse educator is also available to support staff.

To support staff with documentation, 3 desktop computers and four laptops have been installed with access to the electronic clinical documentation system. Each household has also received two additional electronic tablets for medication administration, enabling more than one care staff member to administer medication at the same time. The call bell system has been upgraded to improve monitoring and reporting of response times, and additional alerts have been added to dining rooms and other common areas.

The Assessment Team found most consumers and representatives interviewed said the service has enough of the right staff to meet the needs and preferences of consumers, including timely provision of care and assistance. Consumers described staff as ‘incredible,’ and ‘could not want more from staff.’ Registered nurses and care staff said they had enough time to complete their duties.

Staff noted there are times when a shift is unfilled due to unexpected leave, but the management and registered nurses always help out on the floor. A review of the staff roster for the fortnight prior to the Site Audit showed that all unexpected leave was covered by another staff member or by extending hours of other shifts. Management explained that they are working towards staff in each household being accountable for responses to call bells. The most recent average response time to call bells was under 5 minutes. The service is actively recruiting staff to ensure a stable workforce. Management stated that this has been successful, and their agency staff usage has decreased significantly.

Accordingly, I find requirement 7(3)(a) compliant.

Requirement 7(3)(d)

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Management advised that staff are now receiving more frequent face-to-face training from external providers on food and malnutrition, continence management and wound management. Uniting has introduced a new clinical excellence program focussing on educating registered nurses and enrolled nurses with recent training including pain management and identifying consumer deterioration. The service now has 4 manual handling trainers. Other training delivered includes, manual handling competencies, respectful communication and open disclosure, supporting care staff to better understand the language used in care plans.

During the Assessment contact the Assessment Team found consumers and representatives advised staff know what they are doing, and they are satisfied with the care consumers receive. The service provides an ongoing training program for staff that includes annual mandatory training, additional training in response to identified needs, training by external educators, and on the job training. Training records showed all active staff have completed their annual mandatory training, including infection control, manual handing, serious incident response scheme (SIRS), restrictive practices, code of conduct, hand washing, food handling and emergency response. New staff attend an orientation program with 3 to 4 buddy shifts.

Accordingly, I find requirement 7(3)(d) compliant.

Requirement 7(3)(e)

During the Assessment Contact on 1 August to 2 August 2023 the Assessment Team found the service implemented improvements in response to the non-compliance raised regarding Requirement 7(3)(e) in the 2022 Site Audit, including homemakers (team leaders of each household) have received additional education on how to conduct performance reviews, referred to as ‘continuous conversations,’ resulting in performance reviews occurring within the required timeframes. The performance review document has been simplified to make it more time efficient and to improve recording of employees’ ongoing development.

During the Assessment Contact the Assessment Team found A review of performance appraisal records showed that active staff have current performance appraisals completed. After being recruited performance appraisals are conducted after 3 months and then annually. Evidence of performance management was observed during the Assessment Contact where staff were disciplined, and memos posted when it was observed that personal protective equipment was not being used appropriately.

Accordingly, I find requirement 7(3)(e) compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(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. | Non-compliant |

Findings

The service was found non-compliant in Requirements 8(3)(a) and 8(3)(d) following a site audit from 31 May to 2 June 2022. Regarding Requirement 8(3)(a) The service did not demonstrate that all consumers were engaged in the development, delivery and evaluation of care and services and supported in that engagement. Regarding Requirement 8(3)(d) the service did not demonstrate effective management of high impact and high prevalence risks associated with the care of consumers, nor effective incident management and prevention.

Requirement 8(3)(a)

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Uniting has created a board working group to establish a ‘voice of consumer’ framework to use further strategies to engage consumers in the development, delivery and evaluation of care and services. Weekend community circle meetings have commenced enabling consumers to raise issues/concerns about care delivery, and to provide feedback on the catering at the service. The lifestyle coordinator provides management with a report on the meetings.

During the Assessment Contact the Assessment Team found the service is supporting consumers to engage in the development, delivery and evaluation of care and services using a range of consultative strategies. Consumers and representatives confirmed they believe the service is well run, they are comfortable making comments, suggestions and complaints, management actively seek their feedback and their opinions are heard and valued. Minutes of monthly consumer meetings showed there is discussion about what is happening at the service, including feedback and complaints, improvements, and opportunities for suggestions and comments. There are monthly food focus groups, weekend meetings, board members attend the service quarterly, and the operations management team attends the service at least once a month to engage with consumers and staff.

Accordingly, I find requirement 8(3)(a) compliant

Requirement 8(3)(d)

During the Assessment Contact conducted on 1 August to 2 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. A new organisational governance structure called the ‘Senior Services Quality Assurance Program’ was implemented at the service in July 2023, to improve compliance with all regulatory requirements. Clinical governance committees were rearranged and professionally experienced members added to provide improved clinical oversight. The service now reports on identified trends, risks, risk responses and evidence of improvements to operational management, and the service management team have a monthly governance meeting. The Uniting South Services clinical governance and quality committee functions include clinical performance monitoring and reporting, clinical risk management, reporting on adverse events, and managing complaints and compliments. Weekly ‘notice of direction’ meetings attended by the approved provider’s operational management team were established to oversee and address non-compliance identified in the 2022 site audit and to support the implementation of improvements outlined in the plan for continuous improvement (PCI).

During the Assessment Contact the Assessment Team found the service demonstrated effective governance in relation to responding to abuse and neglect of consumers and supporting consumers to live their best life. However, the service did not demonstrate effective governance in relation to management of some high-impact or high-prevalence risks associated with the care of sampled consumers and managing and preventing some incidents. Care files, service documentation and observations showed there continues to be deficiencies in falls management and wound management resulting in significant risk for consumers.

The Assessment Team found that the organisation has an incident management policy and systems in place that reflect incident management obligations. Staff and contractors (who regularly work at the service) demonstrated an understanding of their roles and responsibilities in relation to incident identification and management. However, there were significant deficiencies found in incident investigations and risk mitigation in risk registers. The organisation’s incident management and investigation systems and processes in areas including risk identification, comprehensive assessment, root cause analysis and incident prevention strategies were not attended for sampled consumers who had multiple wounds and falls. There was a breakdown in the governance oversight of incident reporting, and identification of the service’s greatest high impact, high prevalence risks from operational to board level.

The Assessment Team found the service’s risk governance incorporates risk meetings held at multiple levels, including weekly household meetings, monthly service management team meetings, monthly committee meetings and monthly risk reports submitted by service management to senior management. Ongoing wounds and falls management risks were not clearly identified, analysed and mitigation strategies addressed in line with the Board’s risk appetite. The monthly governance quality report for July 2023 did not identify some high impact high prevalence risks to consumers at the service including wound management and polypharmacy as areas requiring action to be followed up at the next governance session. It was not evident from the report that the board, senior and operational management had a clear and consistent line of sight to these high impact high prevalence risks, and hence the opportunity to address them. Despite regular risk meetings at multiple levels, ongoing wounds and falls management risks were not clearly identified, analysed and mitigation strategies addressed in line with the board’s risk appetite.

In their response to the Assessment Team report, the approved provider disagreed with the Assessment Team’s findings in relation to its organisational governance of high impact, high prevalence risk. The approved provider supplied a detailed outline of the organisation’s complex risk governance system consistent with the Assessment Team’s description. The approved provider advised the clinical governance meeting in July 2023 chaired by the director of governance, risk and quality identified key themes for the reporting period May to June 2023 for the south coast region ‘s residential services. The list of themes/risks did not include falls, pain management or polypharmacy. As a follow-up action from the meeting the organisation organised an external review of clinical documentation and governance processes. The approved provider stated the findings of the review were that clinical governance systems and processes were in place, data was being collated, reviewed and analysed and care planning and assessments were current. The approved provider advised that ‘through the monthly governance and clinical governance process’ a continuous improvement activity was logged on 27 July to work on improving falls management. The approved provider noted that named consumers’ wounds and pressure injuries referred to by the assessment Team continued to improve and/or have healed since the Assessment Contact.

I acknowledge the actions taken by the approved provider to improve its governance of high impact, high prevalence risk and the actions identified in its plan for continuous improvement, including the initiative to improve falls management in late July 2023. However, I have placed more weight on the Assessment Team’s finding that the July governance quality report and corresponding clinical governance meeting did not include falls, wound and pain management, and continuing high levels of polypharmacy at the service as significant key themes/risks to be addressed to ensure the health safety and wellbeing of consumers. Also, the findings of the recent external clinical governance review organised by the approved provider and noted in their response, did not account for the above-mentioned significant risks to consumers health and wellbeing missed in the July 2023 monthly report and clinical governance meeting.

I acknowledge the approved provider noted wounds and pressure injuries of consumers have since improved and healed. However, in their response the approved provider did not supply compelling evidence it has effectively reviewed, evaluated and made improvements to its risk governance system, and in particular its risk line of sight from operational management to the board, to accurately capture and address all high impact, high prevalence risks to consumers in a timely manner. I understand that it will take some time to reflect compliance with this requirement to ensure the improvements are sustained.

Accordingly, I find requirement 8(3)(d) non-compliant.

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