Performance

Report

**1800 951 822**

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| Name: | Uniting Kari Court St Ives |
| Commission ID: | 0548 |
| Address: | 251-257 Mona Vale Road, ST IVES, New South Wales, 2075 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 September 2023 to 7 September 2023 |
| Performance report date: | 9 November 2023 |
| Service included in this assessment: | Provider: 1352 The Uniting Church in Australia Property Trust (NSW)  Service: 5174 Uniting Kari Court St Ives |

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 Kari Court St Ives (**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 (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 5 October 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **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 | **Not Compliant** |

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

# Areas for improvement

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

* Requirement 2(3)(e) – The approved provider ensures that care and services are regularly reviewed for effectiveness, when circumstances change or when incidents occur in the areas of changed behaviours, falls management and wound and pressure injury management
* Requirement 3(3)(a) – The approved provider ensures wounds are always checked and managed according to the consumer's care and services plan, wound documentation and monitoring is consistent with best practice, wound deterioration recognised, and review and/or referral to appropriate wound specialists is attended in a timely manner.
* Requirement 3(3)(a) – The approved provider ensures consumers with changed behaviours are comprehensively assessed, regularly reviewed, reviewed when their behaviour deteriorates and appropriate individualised support strategies are implemented in a timely manner and evaluated for their effectiveness.
* Requirement 3(3)(b) – The approved provider ensures high impact high prevalence risks associated with the care of consumers are identified and effectively managed and mitigated in relation to the management of wound, falls, pain and complex behaviours.
* Requirement 3(3)(g) – The approved provider ensures infection related risks are minimised through the use of standard and transmission-based precautions to prevent and control infection, including the correct use and storage of personal protective equipment (PPE) and hand hygiene practices, clinical waste disposal, regular cleaning of and cleaning between consumer use of equipment such as walkers and wheelchairs.
* Requirement 4(3)(a) – The approved provider ensures that consumers who display challenging behaviours and are unable to initiate activities for their wellbeing and quality of life, are reviewed to engage them in individualised leisure and lifestyle activities that meet their needs and preferences.
* Requirement 8(3)(b) – The approved provider ensures the governing body has effective systems and process in place to promote and monitor that the service has a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Requirement 8(3)(d) – The approved provider ensures the organisation's incident management system effectively identifies, documents, analyses, and mitigates future risk to consumers when incidents occur and staff are trained to use the system effectively.

# Other relevant matters:

In their response to the Assessment Team report, the approved provider supplied a comprehensive plan for continuous improvement that addresses the areas for improvement identified above.

# 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

The service was found non-compliant in Requirements 2(3)(a) and 2(3)(e) following a site audit from 3 May to 5 May 2022.

Requirement 2(3)(a)

During the 2022 site audit the service did not demonstrate assessment and planning processes included appropriate consideration and/or documentation of consumers’ complex care needs in relation to diabetes management and catheter care.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Consumers who required specialised care were assessed for complex care needs, their representatives and general practitioners were consulted as part of the process. Diabetes management resources were distributed to all staff, covering hypoglycaemia and insulin management. Training was delivered on responding to hypoglycaemic episodes. Diabetic management plans and directives from general practitioners were attached to consumers’ medication charts.

During the Assessment Contact the Assessment Team found the service demonstrated they had organisational policies for assessment and care planning. Care documentation showed that these policies and procedures were consistently adhered too. Care plans addressed specific risks to consumer health and wellbeing to inform safe and effective care and service delivery.

In their response to the Assessment Team report, the approved provider did not comment of the Assessment Team’s findings in relation to this requirement.

Accordingly, I find Requirement 2(3)(a) compliant.

Requirement 2(3)(e)

During the 2022 site audit the service did not demonstrate that care and services were appropriately reviewed following changes in consumers’ condition or incidents negatively impacting their health, safety and wellbeing, including episodes of physical aggression and falls.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement.

Meetings were introduced for key clinical staff to review care and services following all incidents and to update the care plan as required. Governance processes were introduced to ensure escalation of changes to consumer’s condition and incidents, including communication about the changes, planned follow-up and evaluation of the effectiveness of care and service strategies used to manage the identified changes.  
  
During the Assessment Contact the Assessment Team found the service did not demonstrate there is a comprehensive review of care plans for effectiveness when circumstances change, or incidents impact consumers' needs, goals or preferences. Consumers and representatives provided positive feedback that they had been informed when consumers’ condition changed. Care documentation for some consumers who had several behavioural incidents showed they were not reviewed in a timely manner to identify underlying unmet needs, contributing factors and mitigation strategies. Referrals were not always made to appropriate behavioural support specialist services to minimise the risk to other consumers’ health safety and wellbeing. Documentation showed consistent deficiencies identified in wound documentation, monitoring and review, preventing correct evaluation of the wound being attended.

In their response to the Assessment Team report, the approved provider acknowledged the findings in relation to this requirement, and advised they would continue to improve the care and service review process for consumers. The approved provider outlined several improvements including the implementation of new and refined systems, processes to ensure regular and timely review of consumers’ care and services and the organisation’s new service governance program and tools, including a new service level action log and risk register, and education programs for registered nurses to return to compliance with this requirement.

I commend the approved provider for the actions it is taking to address the areas for improvement in the Assessment Team Report. However, I consider it will take time for these improvements to be implemented, embedded and sustained in practice.

Accordingly, I find Requirement 2(3)(e) 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(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. | Not Compliant |

Findings

The service was found non-compliant in Requirements 3(3)(a), 3(3)(b), 3(3)(g) following a site audit from 3 May to 5 May 2022.

Requirement 3(3)(a)

During the 2022 site audit the service did not demonstrate that consumers' clinical needs are consistently addressed in a timely manner, with deficits noted in relation to diabetes management, falls management, pain management and management of consumers' weight loss.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Staff received education on pain management, weight loss management and completing electronic incident reports. A falls prevention and management policy, including specific roles and responsibilities for falls management, was implemented.

During the Assessment Contact the Assessment Team found the service did not demonstrate wounds were always checked or managed as per the consumer's care and services plan, and behaviour support plans for consumers with changed behaviours did not follow the Quality-of-Care Principles 2014. Skin assessments and skin integrity care plans were not always reviewed and updated. Deterioration of wounds was not consistently recognised, deficiencies in wound documentation and monitoring, and referrals to appropriate health professionals were not attended to in a timely manner.

Care and service documentation showed changed behaviours were not always documented, goals were generic, and triggers and strategies to manage changed behaviours were not included. Behaviour support plans were not reviewed when circumstances changed. Consumers with changed behaviours were not comprehensively assessed, and appropriate support strategies were not implemented. Recommendations from Dementia Support Australia, while documented, were not implemented for some consumers. Behaviour monitoring charts and detailed evaluations were not always completed.

In their response to the Assessment Team report, the approved provider acknowledged the findings in relation to this requirement, and advised they would continue to improve the care and service review process for consumers. The approved provider outlined several improvements including the implementation of new and refined systems, processes, the organisation’s new service governance program and tools, education programs and meeting and communication strategies to assist staff and management to ensure care and services return to compliance with this requirement.

I commend the approved provider for the extensive actions it is taking to address the areas for improvement in the Assessment Team Report. However, I consider it will take time for these improvements to be implemented, embedded and sustained in practice.

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

Requirement 3(3)(b)

During the 2022 site audit the service did not demonstrate high impact high prevalence risks associated with the care of each consumer were effectively managed by the service.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Staff received education on pain management, weight loss management directives, incident reporting, and they received education on the falls prevention and management policy covering roles and responsibilities for managing falls.

During the Assessment Contact the Assessment Team found the service did not demonstrate high impact, high prevalence risks to consumers were being managed appropriately. Consumers’ health safety and wellbeing were negatively impacted in the areas of falls, wounds and pressure injury management. Care and service documentation showed staff were not following the organisation's policies and guidelines regarding the care of consumers who have had falls including post fall neurological observations. Wounds and pressure injuries were not being regularly checked, measured or re-dressed in accordance with the consumer's care plan. Consumers and representatives provided positive feedback about their general clinical care. However, staff did not demonstrate knowledge of high-impact, high-prevalence risks and strategies to mitigate those risks, including behaviour support strategies to minimise falls risk for consumer’s where this was a contributing factor.

In their response to the Assessment Team report, the approved provider acknowledged the findings in relation to this requirement. The approved provider supplied its plan for continuous improvement containing relevant improvement initiatives and outlined the organisation’s new service governance program. The approved provider advised the service will receive additional governance support including a provision of a relief service manager to assist the current service manager to implement remediation actions. Education programs will be delivered on pressure injury management and classification. Meeting and communication strategies have been introduced to assist staff and management to ensure care and services return to compliance with this requirement. The approved provider stated risk assessments and care plan reviews have been completed in consultation with consumer representatives for consumers identified as refusing wound care.

I acknowledge the approved provider has significantly revised its plan for continuous improvement to address the deficiencies related to this requirement. However, I consider that time, is required to ensure these improvements are effective and sustainable to minimise risk to consumers’ health safety and wellbeing.

Accordingly, I find Requirement 3(3)(b) non-compliant.

Requirement 3(3)(g)

During the 2022 site audit the service was found to be compliant with this requirement. However, during the Assessment Contact conducted from 6 September to 7 September 2023, the Assessment Team observed gaps in infection control and prevention practices, and the scope of the Assessment Contact was extended to include Requirement 3(3)(g).

During the Assessment Contact the Assessment Team found the service had infection prevention policies and procedures and an outbreak management plan, and the service required daily rapid antigen testing (RAT) for all staff, visitors and contractors. Staff and visitors were required to wear surgical masks until day 1 of Assessment Contact. However, several infection control breaches by staff were observed, including masks worn incorrectly, touching of masks without proper hand hygiene, equipment such as walkers and wheelchairs that required cleaning, an unlocked clinical waste bin observed to be full, uncovered personal protective equipment (PPE) storage outside the room of a consumer who was in isolation, incorrect hand hygiene measures used for rubbish removal from consumer rooms.

In their response to the Assessment Team Report the approved provider supplied their updated plan for continuous improvement, including preventive actions such as staff education programs and immediate actions taken to remedy immediate risks including an audit of waste disposal bins.

I acknowledge the approved provider’s willingness to address the infection control issues identified by the Assessment Team and for the preventive actions put in place. However, I consider the approved provider will require time to reflect compliance with this requirement.

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

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The service was found non-compliant in Requirements 4(3)(a) and 4(3)(e) following a site audit from 3 May to 5 May 2022.

Requirement 4(3)(a)

During the 2022 site audit the service did not demonstrate consumers received safe and effective services and supports for daily living. Staff did not always support consumers to remain as independent as possible, optimising their quality of life. Services and supports for daily living were not safe and effective or provided in accordance with consumers' needs, goals and preferences. Lifestyle activities were not individualised to meet the needs of consumers who displayed behaviours of concern.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service arranged for dementia and behaviour specialists to identify behaviour management issues at the service. There has been ongoing staff education on behaviour support for consumers living with dementia and behaviour support planning, and staff have been empowered to create meaningful activities with residents.

During the Assessment Contact the Assessment Team found the service did not provide effective supports for daily living for consumers who display challenging behaviours and are unable to initiate activities for their wellbeing and quality of life. While some consumers said they were satisfied with their lifestyle in the service, other consumers and representatives interviewed said there was not enough stimulation nor sufficient activities provided for consumers. Staff said most consumers at the service live with cognitive impairment or dementia and there are not enough staff to spend time on one-to-one consumer engagement. Care documentation showed not all consumers living with dementia have a complete or current lifestyle care plan, and care plans do not consistently identify supports for daily living to optimise their quality of life. The Assessment Team noted that lifestyle staff were familiar with individual consumers leisure and lifestyle preferences.

In their response to the Assessment Team report, the approved provider advised that prior to the Assessment Contact the organisation’s dementia specialist reviewed how effectively the service was meeting consumers’ needs and preferences and a behaviour support project was commenced to enhance consumer engagement. Consumers’ behaviour support plans, lifestyle plans and program are being reviewed. For consumers who regularly refuse to participate in activities of daily living, an external dementia support service will be assisting the service to explore additional strategies to manage increased changed behaviours.

The approved provider submitted their plan for continuous improvement for the service that includes several actions to address the issues identified in this requirement. I encourage the approved provider to include more detailed actions arising from the behaviour support project in their plan for continuous improvement. In particular, actions to improve the identification of effective individualised engagement strategies and activities to meet the needs of consumers displaying challenging behaviours, who are unable to initiate activities for their wellbeing and quality of life.

I acknowledge the approved provider’s response, their willingness to address the issues identified by the Assessment Team, and the work already commenced to review and improve person centred services and supports for daily living, prior to the Assessment Contact. However, I consider it will take time for the approved provider to reflect compliance with this requirement.

Accordingly, I find Requirement 4(3)(a) non-compliant.

Requirement 4(3)(g)

During the 2022 site audit the service did not demonstrate that service equipment was always cleaned and maintained to ensure it was safe and suitable. There were no instructions for staff to clean equipment provided by the service.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service organised a cleaning schedule with an external cleaning contractor. Staff were provided education on their cleaning duties and responsibilities for sanitising all equipment between resident use.

During the Assessment Contact the Assessment Team found that on balance the service has been able to demonstrate that the equipment provided to residents is clean and safe. The service has a process in place for reporting and resolving maintenance issues and completing regular maintenance tasks. The Assessment Team observed that the equipment provided to consumers during several group activities was safe, clean, in good condition, and suitable for consumer use. Consumers and representatives expressed satisfaction with the cleanliness and maintenance of support equipment provided to consumers.

The Assessment Team observed some equipment used by consumers, such as wheelchairs, portable tables, and walkers, were not cleaned after each use. This was raised with management during the visit. Management confirmed that the care staff are responsible for cleaning resident equipment and that they would follow up with the current practices.

In their response to the Assessment Team report, the approved provider did not comment of the Assessment Team’s findings in relation to this requirement.

Accordingly, I find Requirement 4(3)(g) compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service was found non-compliant in Requirement 5(3)(c) following a site audit from 3 May to 5 May 2022.

During the 2022 site audit the service did not demonstrate that furniture, fittings, and equipment were safe, clean, well maintained and suitable for the consumer.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service has an external contractor that conducts 3 monthly audits on furniture and upholstery in dining and lounge areas and consumers’ rooms. The external contractor conducts detailed cleaning of consumers’ rooms and bathrooms each week.

During the Assessment Contact the Assessment Team found most consumers and representatives expressed satisfaction with the cleanliness of furniture and fittings.

The Assessment Team observed beds, furniture and bathrooms were all clean and well-maintained across several wings. Maintenance documents confirmed fittings and equipment are maintained and cleaned.

In their response to the Assessment Team report, the approved provider did not comment on the Assessment Team’s findings in relation to this requirement.

Accordingly, I find Requirement 5(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)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

The service was found non-compliant in Requirements 7(3)(a) and 7(3)(c) following a site audit from 3 May to 5 May 2022.

Requirement 7(3)(a)

During the 2022 site audit the service did not demonstrate the workforce is planned with the right number and mix of staff to enable the delivery and management of safe and quality care and services to consumers. The Site Audit team observed some consumers who displayed changed behaviours were not engaged in activities, particularly in the afternoons. Staff advised they often had to assist other team members to complete their work which meant not all consumers’ preferences could be met all of the time.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. New roles, including homemaker, leisure and lifestyle coordinator and wellness officer, and an afternoon registered nurse were introduced. Dementia-specific programs to support consumers with complex consumer behaviours were developed. Management monitored call bell response times weekly and addressed excess wait times with staff.

During the Assessment Contact the Assessment Team found the service did not demonstrate it had sufficient staff to deliver safe and quality care and services to meet the needs of consumers with changing behaviours. Most staff interviewed, said the workload was often very challenging, particularly on the second floor, where there were more consumers living with dementia who had challenging behaviours. Management acknowledged the service had experienced significant staff shortages for an extended period. Consumers, representatives and staff members consistently stated that the service did not have sufficient staff to provide timely and quality care and services, in areas such supporting consumers with challenging behaviours. Staff attendance sheets showed 15 unallocated shifts in the previous 3-week period.

In their response to the Assessment Team report, the approved provider advised that based on the feedback received during the assessment contact, the organisation has reviewed the current budget and care minute allocation as well as the service’s organisational structure. A full-time qualified leisure and wellness officer has commenced, and there has been a significant increase in hours for the wellness officer, leisure and lifestyle coordinator and care coach. Current job vacancies have been advertised. The 24/7 registered nurse schedule has now been filled with 4 new registered nurses recruited in August 2023. Casual staff have been recruited as part of a contingency plan to replace staff going on planned leave, and a senior service manager has been deployed temporarily to mentor and support the new service manager and registered nurses to enhance their leadership skills.

I acknowledge the findings in the Assessment Team report. However, I commend the significant actions taken by the approved provider since the Assessment Contact to increase the number and improve support of care staff, registered nurses, leisure and lifestyle and management to address identified deficits in the delivery and management of safe and quality care and services.

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

Requirement 7(3)(c)

During the 2022 site audit the service did not demonstrate effective systems to ensure staff had appropriate qualifications, knowledge and skills to effectively undertake some tasks, such as conducting post fall neurological observations. Management were not aware that this task was being conducted by staff who were not qualified to do so.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. A memo was sent to staff to ensure they provided care within their scope of practice. The memo included the procedure for accessing after-hours assistance for neurological observations if required.

During the Assessment Contact the Assessment Team found the service demonstrated staff have the qualifications and knowledge to effectively perform their roles. The head of operations confirmed that the organisation's human resource department undertakes recruitment and monitoring of staff qualifications, police checks and registrations. Compulsory competency training is undertaken for manual handling, PPE donning and doffing, handwashing, medication competency and fire training. Management advised that new position descriptions have been documented for all roles at the service.

In their response to the Assessment Team report, the approved provider did not comment on the Assessment Team’s findings in relation to this requirement.

Accordingly, I find Requirement 7(3)(c) compliant.

# Standard 8

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

Findings

The service was found non-compliant in Requirements 8(3)(b), 8(3)(c) and 8(3)(d) following a site audit from 3 May to 5 May 2022.

Requirement 8(3)(b)

During the 2022 site audit the organisation did not demonstrate the governing body effectively promoted and monitored processes to ensure a culture of safe, inclusive, quality care.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. A care coach position was introduced to provide ongoing staff education, support and oversight in relation to complex care. Care hours of registered nurses were increased to support resident care. Weekly and monthly clinical governance meetings with the clinical team were implemented to discuss issues, trends, complaints and residents requiring close monitoring. Staff received education on the escalation process for when a consumer’s condition deteriorates and incidents occur, such as falls, complex behaviours and weight loss.

During the Assessment Contact the Assessment Team found the organisation did not demonstrate the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Monthly clinical governance monitoring reports at both the service and regional team levels did not provide sufficient information on high-impact, high-prevalence risks associated with the care of consumers. Risk governance at the regional level focused on high level monitoring of clinical quality and risk across the region. There was insufficient detailed information provided for effective monitoring and mitigation of clinical quality deficits and risk trends at the service level. The service manager’s report indicated that the consumer risk register is still in progress. Regional management advised the organisation implemented a restructure in November 2022 that introduced several regional support staff, quality improvement and educator roles to improve mitigation of risk to consumers.

In their response to the Assessment Team report, the approved provider advised and supplied documented evidence that in response to the 2022 site audit findings the organisation is in the process of implementing a new service level clinical governance program (including revised tools, reporting and processes) to be completed by 1 November 2023 and evaluated no later than May 2024.

I commend the approved provider for the risk and clinical governance improvement program it is implementing at the service to promote a safe, inclusive quality care and culture. I encourage the approved provider to ensure accountability for this program is embedded at all levels of organisational governance from the board to the service level to ensure the improvements are sustained. I consider this will require time to be achieved.

Accordingly, I find Requirement 8(3)(b) non-compliant.

Requirement 8(3)(c)

During the 2022 site audit the organisation did not demonstrate effective workforce governance and regulatory compliance systems.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service continued its recruitment process to fill vacant shifts and implemented weekly call bell monitoring.

During the Assessment Contact the Assessment Team found the service demonstrated effective organisation wide governance systems in the areas of information management, continuous improvement, financial governance, feedback and complaints. However, the Assessment Team identified there were deficits in the organisation’s incident management system. This is considered in Requirement 8(3)(d). In relation to workforce governance the Assessment Team identified there were insufficient staff to provide meaningful activities for consumers and to monitor consumers’ changing behaviours. This was considered in Requirement 7(3)(a).

In their response to the Assessment Team report, the approved provider supplied evidence to show the additional roles created and staff employed since the service transitioned to the household model of care in 2022, as well as registered nurse recruitment to meet the legislative 24/7 staffing requirements. In addition, the approved provider noted the bus driver’s hours were increased to facilitate more bus trips for consumers during the week. The approved provider also noted the new service level clinical governance program implemented at the service. This was considered in Requirements 8(3)(a), 8(3)(d), 3(3)(a) and 3(3)(b).

I acknowledge the findings of the Assessment Team. However, I consider the issues raised in relation to incident and workforce governance have been dealt with in the other requirements. Therefore, I have placed more weight on the Assessment Team’s positive findings in relation to governance of information management, continuous improvement, financial management, feedback and complaints.

Accordingly, I find Requirement 8(3)(c) compliant.

Requirement 8(3)(d)

During the 2022 site audit the organisation did not demonstrate effective management of high impact/high prevalence risks associated with consumer care in the areas of falls management and complex behaviour support. Falls monitoring processes were found ineffective in relation to timely identification of negative outcomes for consumer falls, and repetitive incidents of complex consumer behaviours were not managed in a timely manner to ensure their needs were addressed.

During the Assessment Contact conducted from 6 September to 7 September 2023, the service provided evidence that it has implemented the following improvements to meet the requirement.

A weekly and monthly clinical governance meeting has been implemented to discuss issues, trends, complaints and residents whose condition requires close monitoring. Staff have been educated in the escalation process for clinical deterioration in areas such as weight loss, unmanaged pain, and incidents of falls and complex behaviours.

During the Assessment Contact the Assessment Team found the service did not demonstrate high impact or high prevalence risks associated with the care of consumers are effectively managed. This was addressed in Requirements 2(3)(a), 2(3)(e), 3(3)(a) and 3(3)(b). The organisation had up-to-date clinical, risk management and incident management policies and procedures, but the Assessment Team found they were not always followed by staff. Care Consumers with complex behaviours and those with a high falls risk were not effectively managed and monitored. The organisation is in the process of implementing a new service level clinical governance program. However, the Assessment Team found the organisation's incident management system was not yet effectively identifying, documenting, analysing, managing and putting in place risk mitigation strategies when incidents occurred.

In their response to the Assessment Team report, the approved provider noted its new clinical governance program, outlined the strategies it has in place to effectively manage risk to consumers. This was addressed in Requirements 7(3)(a), 7(3)(c) and 8(3)(a).

I acknowledge the approved provider’s commitment and actions taken to improve the organisation’s risk management system and practices. However, I consider it will take time for these changes to be consolidated and 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)