Performance

Report

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| Name of service: | Warrawee Nursing Home |
| Service address: | 854A Centre Road EAST BENTLEIGH VIC 3165 |
| Commission ID: | 4444 |
| Approved provider: | City of Glen Eira |
| Activity type: | Site Audit |
| Activity date: | 4 October 2022 to 6 October 2022 |
| Performance report date: | 18 November 2022 |

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 Warrawee Nursing Home (**the service**) has been prepared by James Howard, 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 upon

The following information has been considered in preparing the performance report:

* the Assessment Team’s report for the site audit conducted from 4 October 2022 to 6 October 2022; the site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the Approved Provider’s response to the site audit report, received 2 November 2022.
* other information and intelligence held by the Aged Care Quality and Safety Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **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.

* *Requirement 2(3)(d)* – The service must ensure outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to consumers and representatives.
* *Requirement 5(3)(b)* – The service must ensure the service environment enables consumers to move freely, both indoors and outdoors.
* *Requirement 7(3)(d)* – The service must ensure the workforce is trained and supported to deliver the outcomes required by the Quality Standards.
* *Requirement 7(3)(e)* – The service must ensure it undertakes regular assessment, monitoring and review of the performance of each member of the workforce.
* *Requirement 8(3)(c)* – The service must ensure it has organisation-wide governance systems which guide workforce and regulatory compliance.
* *Requirement 8(3)(e)* – The service must ensure it has a clinical governance framework that promotes antimicrobial stewardship, minimises the use of restraint and requires an open disclosure process when things go wrong.

# Standard 1

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

Findings

The Quality Standard is assessed as Compliant as six of the six specific requirements were assessed as Compliant.

Consumers said staff treated them with dignity and respect, and valued their identities and cultures. Consumers’ care plans included details of individual cultural and diversity needs. Staff interactions with consumers were respectful, which was reflected by consumers who had mutual respect for their carers. The lifestyle coordinator was familiar with consumers from culturally diverse backgrounds and used this knowledge to plan leisure and wellness events.

Consumers said they decided who would be involved in their care and the way it was delivered. Consumers said they were supported to maintain relationships and exercise choice and independence in their daily care. For example, couples at the service were supported to spend time alone together, whilst others maintained family contact through digital and face-to-face communication. Consumers were supported to take risks and participate in risk assessments, consultations with health professionals, planning and decision-making. For example, consumers with food associated hazards were supported in their choice to take risks, as it helped them live their best lives.

Consumers received current, accurate and timely information via an activity calendar, weekly newsletter, noticeboards, resident/relative/friends meetings and discussions with staff. The Assessment Team observed staff speaking to consumers with cognitive difficulties, to ascertain their menu choices. Consumers said staff respected their privacy by knocking on doors prior to entering. The service had policies for the privacy and protection of consumers’ information, which included storage, security and disclosure. A review of the consumer handbook included information about how the service managed privacy and protection of personal information.

# 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)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirement 2(3)(d).

*Requirement 2(3)(d):*

The service conducted a range of consumer assessments and care planning that recognised risks, identified needs and determined preferences and goals. However, the Assessment Team noted consumers and representatives were unaware of their care plans, did not know they could request a copy, nor were copies offered to them by the service. During the site audit, management acknowledged care plans had not been offered to consumers and their representatives, though doing so now formed part of the service’s continuous improvement plan.

In its response of 2 November 2022, the Approved Provider advised it carried out a review of its processes following the Site Audit and provided documented evidence of remedial actions, which included:

* Implementing an updated Resident of the Day policy, which entailed reviewing a different consumers’ needs each day. The updated policy included training for the clinical team in the new consumer review process.
* Sending communication to all consumers and their representatives which explained what care plans were, why they were in place, the Resident of the Day process and the purpose of reviewing care plans.
* Establishing a Gerontology Fast Track Training (RN Bootcamp), which is a two-week program which commenced on 5 October 2022 and required staff to offer consumers and their representatives a copy of the care plan.

I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified in the site audit report. However, at the time of the Site Audit, management acknowledged consumers and their representatives were not been offered access to their care plans. Although the service is making changes, it is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, at the time of the site audit, I find the service was non-compliant with Requirement 2(3)(d).

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 2.

The service conducted a range of consumer assessments and care planning that recognised risks, identified needs and determined preferences and goals. Clinical and care staff said they followed the service’s admission checklist guide to ensure planning commenced on entry and remained ongoing. Assessment and planning occurred in consultation with consumers and their representatives, who confirmed needs and preferences were considered in care planning, along with an assessment of risk.

A review of consumers’ care plans showed the service addressed their needs, goals and preferences, which included end-of-life planning if the consumer wished. Most consumers and their representatives were satisfied with assessment and care planning at the service, which included people and health care professionals whom the consumers wanted involved in their care. A review of consumers’ care plans confirmed medical and allied health professionals were involved in care planning and delivery. The service reviewed consumers’ care and services when their circumstances changed, though management acknowledged it was in the process of ensuring all consumer reviews were current.

# 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)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission-based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Quality Standard is assessed as Compliant as seven of the seven specific requirements were assessed as Compliant.

Consumers said the care they received was safe, effective, tailored to their needs and optimised their health and well-being, which was confirmed by a review of their care plans. To increase efficient care delivery, consumers were allocated their own equipment such as mobility aids, to ensure delays were minimised. The service effectively managed consumers’ risks such as falls, choking hazards, pain, nutrition and hydration, cognitive decline and skin integrity through conducting clinical needs assessments and implementing mitigation strategies agreed upon with consumers.

Consumers nearing the end of life had their dignity preserved and care was delivered in line with their wishes, which were recorded in care plans. Staff described how care delivery changed for consumers nearing end of life, including comfort care, pressure area care and pain management. The service accessed community palliative care services to support consumers during nearing the end of life. The service recognised the deterioration of consumers’ conditions and responded to their needs in a timely manner. Consumers’ conditions were monitored in clinical management meetings, through reviewing clinical indicators and discussions with the care team during shift handover meetings. Consumers were happy with the management of changes to their conditions.

Consumers’ care plans and progress notes included information which supported effective sharing about their conditions, preferences and care needs where the responsibility for care was shared. The service followed procedures when making referrals to health professionals externals to the service, which included electronic messaging and phone communication. A review of consumers’ care plans confirmed they were referred to health care professionals as needed. The service had processes in place to minimise infection-related risks and support the appropriate prescribing of antibiotics.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is assessed as Compliant as seven of the seven specific requirements were assessed as Compliant.

Consumers said the service provided supports for daily living which met their needs, goals and preferences. Staff were knowledgeable of, and able to discuss, consumers’ needs, goals and preferences. Consumers’ care plans included supports needed to do things of interest to them, such as visiting local shops, which optimised their independence, well-being and quality of life. Consumers described services and supports available to promote emotional, spiritual and psychological well-being, such as one-on-one emotional support, yoga and maintaining contact with family and friends. Consumers said they felt connected with and engaged in meaningful and satisfying activities.

Consumers said the service supported them to participate in the community, both within and outside of the service. Consumers had input into activities provided by the service, which was confirmed by the Assessment Team’s review of activity planners that included outings to an art exhibition, the local beach and shopping trips.

The service provided consumers with varied meals of suitable quality and quantity, which was confirmed by most consumers and noted by the Assessment Team. The four-week rotating menu was determined by the likes and dislikes of consumers. The service’s chef said changes to consumers’ dietary needs were received daily from clinical staff, via printed forms from an electronic care management system.

Where the service provided equipment, it was safe, suitable, clean and well maintained, which was confirmed by consumers. The Assessment Team reviewed the service’s electronic maintenance system which showed scheduled preventative and corrective maintenance. Lifestyle staff said equipment such as sound systems, gardening equipment, arts and craft materials, trolleys and iPads were accessible and well maintained.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirement 5(3)(b).

*Requirement 5(3)(b):*

Consumers said the service was clean and the Assessment Team noted most areas were safe, well maintained and comfortable. The service design allowed free movement within the building and easy access to sitting rooms and dining areas. Whilst consumers could move freely indoors, not all were able to move outside as they were not given access codes for the doors’ keypads. The Assessment Team noted staff were unfamiliar with environmental restraint and thought consumers could not leave the service for their own safety. Management recognised a collective service deficiency in restrictive practice knowledge, and advised the service would address this through staff training.

The Assessment Team advised management of their observations during the site audit, and management acknowledged the situation constituted environmental restraint. Management advised the issue would be added to the service’s continuous improvement register; consumer assessments would be updated; consent forms sought from consumers who could safely leave the service; and the service would provide consumers not under environmental restraint with the door access codes.

In its response, the Approved Provider acknowledged the Assessment Team’s findings and provided documented evidence of the remedial actions being taken. These included:

* Promptly providing consumers with door access codes during the site audit.
* Introducing mandatory training modules, one of which addressed restrictive practices.
* Requiring staff to attend a restrictive practice refresher module in December 2022.
* Releasing an updated Restrictive Practice Manual to all staff, both electronically and in hard copy.
* Displaying the Commission’s Perimeter Environmental Restraint Self-Assessment Tool poster as a quick reference guide for staff in nursing stations and management offices.
* Adding restrictive practice as an agenda item to clinical meetings and the monthly quality and risk meeting.
* Sending information to consumers, representatives, relatives and staff, advising of where to find access codes for external doors, how they are used and how keypads are considered environmental restraint.

I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified in the site audit report. However, at the time of the site audit, management acknowledged consumers, representatives, staff and management had an inadequate understanding of restrictive practices. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, at the time of the site audit, I find the service was non-compliant with Requirement 5(3)(b).

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 5.

Consumers said the service environment was welcoming to them, their friends and family and they felt a sense of belonging. The service had sunrooms and spaces where consumers could socialise or sit quietly. Consumers said the service was easy to navigate and they could find dining, activity and lounge areas. Consumers personalised their rooms with furniture from home, which contributed to their sense of belonging at the service.

Consumers said furniture and fittings met their needs and preferences, which the Assessment Team observed were clean and fit-for-purpose. Staff said they had enough equipment to deliver care, which they cleaned with disinfectant between uses. The Assessment Team noted the service had an effective preventative and reactive maintenance program in place and items were promptly repaired or replaced as required.

# 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

The Quality Standard is assessed as Compliant as four of the four specific requirements were assessed as Compliant.

Consumers and representatives advised the service encouraged them to provide feedback and make complaints, and they felt comfortable raising issues with staff or management. The service encouraged feedback and complaints through: a formal feedback form; raising issues at the resident and relative meetings; and brochures advertising external complaints mechanisms. The Assessment Team reviewed the service’s continuous improvement register, which showed consumer feedback and complaints were documented, trended and scheduled for planned actions within dedicated timeframes. The service used the continuous improvement register to improve the quality of care and services.

Consumers and representatives said they were aware of other avenues for raising a complaint, though they were comfortable approaching staff in the first instance. Staff and management understood how to support consumers and representatives to access interpreter and advocacy services, which were also advertised on noticeboards throughout the service. Consumers and representatives said management promptly addressed their concerns when complaints were made, or when an incident occurred. The service’s incident management system showed staff and management applied open disclosure following adverse incidents, in tandem with responding to consumer/representative concerns in a timely way.

# 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 7(3)(d) and 7(3)(e).

*Requirement 7(3)(d):*

Consumers and representatives raised concerns about staff training in manual handling and the use of lifting machines. Feedback provided to the Assessment Team was specific to three consumers who experienced pain when lifting machines were needed by staff to deliver personal care. Feedback included the concern that staff did not always recognise or respond to consumers’ pain whilst in a lifting machine. Staff advised the Assessment Team they could not recall when the service last offered manual handling training.

The Assessment Team advised management of the feedback about staff training in manual handling. Management acknowledged the service did not have a mandatory staff training schedule in place. However, the service had a draft mandatory training schedule which had not yet been approved by the governing body. Management advised since they commenced at the service in June 2022, the service had offered informal, non-mandatory training on restrictive practices, clinical deterioration, wound management and infections.

In its response, the Approved Provider acknowledged the Assessment Team’s findings and provided documented evidence of the remedial actions being taken, which included:

* Creating a mandatory education schedule and circulating it to all staff.
* Conducting mandatory manual handling training across three days in October 2022, with additional sessions organised until all staff have completed the training.
* Ensuring all clinical and care staff complete mandatory training on the Serious Incident Response Scheme, restrictive practices and the use of open disclosure when things go wrong.
* On 5 October 2022, registered nurses commenced a six-week Gerontology Fast Track Course which addressed education, support and providing best practice aged care services.

I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified during the site audit. However, at the time of the site audit, management acknowledged the lack of staff training in manual handling. The service is still implementing its remedial actions and it will take time for them to be fully effective. Therefore, at the time of the site audit, I find the service was non-compliant with Requirement 7(3)(d).

*Requirement 7(3)(e):*

Management advised the service did not have a formal process for annual staff performance appraisals. The service informally monitored staff performance through observations and the analysis of internal audits, clinical data and feedback from consumers, representatives and staff. Management said it was working with the organisation’s People and Culture Team to develop a list of dates by which annual performance appraisals must be completed. Staff performance appraisals were included in the service’s continuous improvement plan, which was confirmed by the Assessment Team.

In its response, the Approved Provider acknowledged the Assessment Team’s findings and provided documented evidence of the remedial actions being taken, which included:

* Sending written advice to staff about the performance appraisal process, which was scheduled to commence on 1 November 2022.
* Sending a performance appraisal form to eight staff, and scheduling performance appraisal meetings with those staff.

I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified during the site audit. However, at the time of the site audit, management acknowledged the absence of a formal staff performance appraisal program, as required by the Quality Standards. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, at the time of the site audit, I find the service was non-compliant with Requirement 7(3)(e).

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 7.

Consumers said there were sufficient staff to meet their needs and promptly attend to calls for assistance. Staff said there were enough rostered staff to provide care and services in accordance with consumers’ needs and preferences, within allocated timeframes. Consumers and representatives said staff were respectful, caring and kind when providing care. Staff had a good working knowledge of consumers’ needs and preferences. Staff knowledge of consumers’ needs and preferences was consistent with care plans.

# 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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 8(3)(c) and 8(3)(e).

*Requirement 8(3)(c):*

The service had organisation wide governance systems that guided continuous improvement, financial governance and feedback and complaints.

However, there was a lack of governance regarding workforce and regulatory compliance, and this had an impact on consumer care.

With respect to workforce governance, the Assessment Team’s findings were based on the absence of mandatory training and formal performance appraisals, which have been addressed elsewhere in this report.

In its response, the Approved Provider acknowledged the Assessment Team’s findings regarding workforce governance and provided documented evidence of the remedial actions being taken, as described in Requirements 7(3)(d) and 7(3)(e), and applied by the organisation to support effective workforce governance systems.

With respect to regulatory compliance, the Assessment Team’s findings were based on a policy manual which was inaccurate and referenced superseded aged care legislation. Though the service had an updated draft policy manual which included an Approved Provider’s legislated responsibilities, it had not been implemented and, therefore, not given to staff.

In its response, the Approved Provider acknowledged the Assessment Team’s findings about regulatory compliance and provided documented evidence of the remedial actions being taken, which included:

* Releasing an updated policy manual to all staff which, complimented by mandatory training to ensure an understanding of new content and the importance of regulatory compliance.
* Providing mandatory staff training which addressed the Quality Standards, antimicrobial stewardship, elder abuse, unexplained absences, open disclosure, minimising restrictive practices and the Serious Incident Response Scheme.

I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified during the site audit. However, at the time of the Site Audit, management acknowledged there was a lack of governance regarding workforce and regulatory compliance. The service is still implementing its remedial actions as detailed above and it may take time for them to be fully effective. Therefore, at the time of the site audit, I find the service was non-compliant with Requirement 8(3)(c).

*Requirement 8(3)(e):*

The organisation did not have a documented clinical governance framework which promoted antimicrobial stewardship, minimised the use of restraint or required an open disclosure process when things go wrong. Notwithstanding, the Assessment Team noted staff understood antimicrobial stewardship and open disclosure, although their understanding of restrictive practices was deficient.

In its response, the Approved Provider acknowledged the deficiencies identified in the site audit report and provided documented evidence of the remedial actions being taken, which included:

* Release of a clinical governance framework, used by the workforce daily.
* Release of an antimicrobial stewardship policy to all staff and visiting medical officers.
* Addition of antimicrobial stewardship as an agenda item for the medication advisory committee, clinical meetings and staff meetings to identify trends and reduce the unnecessary prescribing of antibiotics.
* Release of an updated restrictive practice manual, complemented by mandatory staff training, with refresher education scheduled for December 2022.
* Release of an incident management policy, which addresses open disclosure.
* Mandatory staff training about open disclosure.

I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified in the site audit report. However, at the time of the site audit, management acknowledged the absence of a documented clinical governance framework. The service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, at the time of the site audit, I find the service was non-compliant with Requirement 8(3)(e).

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 8.

Consumers and representatives were confident the service was well run and they were satisfied with their level of engagement in the development, delivery and evaluation of care and services. Management said consumer feedback resulted in the choice of updated dining room furniture. Consumers were engaged through resident and representative meetings, clinical care meetings and surveys about food and lifestyle activities. The Assessment Team viewed documentation which confirmed consumers and representatives were involved in the evaluation of care and services.

The organisation’s governing body showed it promoted a culture of safe, inclusive, quality care and services and was accountable for their delivery. For example, the governing body introduced new management to the service, following which new processes to monitor service performance were introduced. The governing body received consolidated monthly service reports which informed them of internal audit results, consumer/representative and staff feedback and complaints, continuous improvement initiatives, hazards and risks and clinical and incident data analysis. The information was used to enhance performance against the Quality Standards, initiate improvements and monitor service delivery.

The service had a draft risk management framework and policies which addressed the management of high-impact and high-prevalence risks to consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live their best lives; and preventing and managing incidents. Staff described risk mitigation strategies concerning fall prevention, infection prevention and managing challenging consumer behaviours.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)