Performance

Report

**1800 951 822**

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| Name of service: | Wesley Rayward |
| Service address: | 3 Dalmar Place Carlingford NSW 2118 |
| Commission ID: | 1007 |
| Approved provider: | Wesley Community Services Limited |
| Activity type: | Site Audit |
| Activity date: | 8 November 2022 to 11 November 2022 |
| Performance report date: | 3 January 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 Wesley Rayward (**the service**) has been prepared by K.Spurrell, 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 Site Audit. The Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 20 December 2022.
* other information and intelligence held by the 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 | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **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 8(3)(c) – the Approved Provider ensures effective management relevant to recording, storing and distribution of information and said sources of information are accessible to all members of the workforce.

# 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 Service was found non-compliant in Standard 1 in relation to Requirement 1(3)(a) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement.

Consumers said they were treated with dignity and respect, and their cultural needs and preferences were supported. Staff consistently spoke about consumers in a respectful manner and were familiar with consumers’ life experiences, and described how care and services were adapted for each consumer, such as conversing in a consumer’s preferred language. Care plans detailed consumers’ identity, culture, and diversity information.

Consumers expressed they felt safe at the service and staff respected any culture and religion they identified with. Staff had an awareness of consumers from a culturally diverse background, and explained how they provided care that aligned with their care plan. The service engaged consumers in religious services and celebrations regarding their heritage.

Consumers and representatives considered consumers were supported to exercise choice and independence, decide who was involved in their care, and to maintain relationships. The service supported married consumers to maintain their relationship, including respecting couples who had chosen to reside in separate rooms.

The Service was found non-compliant in Standard 1 in relation to Requirement 1(3)(d) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives said consumers were supported to take risks which enabled them to live their best lives. The service completed risk assessments which supported consumers to make informed risk taking decisions and implemented safety strategies.

Consumers were provided timely information that was accurate, easy to understand and enabled them to exercise choice. Regular consumer meetings occurred and meeting minutes were posted in communal areas for consumers. Staff described how they facilitated various communication methods to suit consumers’ needs. Menus, activity calendars and notices were displayed throughout the service.

Consumers reported their privacy and confidentiality was respected, and described staff practices such as knocking on doors prior to entry and closing the door during provision of personal care. This was consistent with staff feedback. The service had protocols in place to protect consumers’ privacy.

# 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. | 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

The service conducted assessment and planning with consumers and representatives with considerations to risks. Care planning documents reflected effective processes were in place to identify the needs, goals, and preferences of the consumers, including advance care planning and end of life care.

Consumers and representatives said they were satisfied with the quality of care and services they received, assessment and planning was based on partnership with them, and included others they chose to involve in their care. Care planning documents evidenced involvement and input from the consumer and representative, medical officers, and other allied health professionals.

Consumers and representatives confirmed they were consulted about changes to their care, and were comfortable letting the service know if they wished to change their care. Staff advised they communicated outcomes of assessment and planning to consumers by talking to consumers and their families directly, or via telephone.

Care planning documents had been reviewed every three months, or earlier if any changes to a consumer’s condition was recognised or any incidents had occurred.

# 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 Service was found non-compliant in Standard 3 in relation to Requirement 3(3)(a) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers received safe and effective personal and clinical care that was best practice, tailored to their needs and optimised their health and wellbeing. Staffs’ knowledge of consumer’s needs, goals, and preferences enabled them to identify what was best practice when attending to their personal care.

Care planning documents identified appropriate management of some high impact and high prevalence risks applicable to consumers’ care needs. The Site Audit Report however, brought forward evidence that risk assessments were not updated for two named consumers. Upon the Assessment Team liaising with management at the time of the Site Audit, and taking all information into consideration, the Assessment Team was satisfied there was no direct impact for these consumers.

Consumers felt their end of life needs and preferences will be met, and their comfort maximised. Family members were supported during visits with their loved ones on their end of life pathway. The service had policies and procedures to support staff in the management of end of life care, including pain management and comfort care.

Care planning documents reflected the identification of, and response to, deterioration or changes in consumers’ condition and health status. Staff were guided by policies and procedures that supported them to recognise and respond to deterioration or changes. This was consistent with consumer and representative feedback.

Information about consumers’ condition, needs and preferences were documented and communicated where the responsibility of care was shared, as reflected in care planning documents. Staff described how information about consumer needs, conditions, and preferences were documented and communicated, including through verbal handover processes, meetings, accessing care plans, and electronic notifications on the services electronic care management system (ECMS).

Consumers and representatives said referrals to other health professionals were timely and occurred when needed. Staff described the process to refer clinical matters to other providers.

The Service was found non-compliant in Standard 3 in relation to Requirement 3(3)(g) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives were satisfied with precautions in place to manage infectious outbreaks, including those involving COVID-19. Staff demonstrated knowledge of hand hygiene, and the importance of wearing face masks. Infection prevention and control training was mandatory for staff and part of their induction.

# 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 Service was found non-compliant in Standard 4 in relation to Requirement 4(3)(a) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers were supported to do things of interest, and the service’s lifestyle program supported their needs. Consumer feedback was used to develop the lifestyle program and activities offered at the service.

Consumers said their emotional, spiritual and psychological needs were supported. Staff supported consumers to communicate with their families, and encouraged consumers to attend activities of interest. Information in care planning documents regarding consumer’s spiritual, emotional needs and life experiences, directed how staff engaged with consumers.

The service supported consumers to participate in activities within the service and the outside community. Staff described how they worked with community groups to enable consumers to follow their interests and community connections. Consumers and representatives confirmed consumers are supported to keep in contact with people important to them.

Consumers considered information was adequately communicated between staff. Staff described how communication of consumers’ needs and preferences occurred via care plans and shift handover. Information was shared with relevant staff and updated on the service’s electronic care management system (ECMS).

Consumers said the service assisted them with referrals to individuals, other organisations and providers of other care and services, and they had free access to the library, church and hairdressing services. Staff said the service accessed volunteers and pastoral carers to provide additional one-to-one support for consumers who preferred not to or were unable to attend activities, or were on palliative and/or end of life care.

Most consumers said the meals provided were of suitable variety, quality and quantity, and they were offered two choices for main meals. Consumers were offered a range of other options where the options were not to their liking. Consumers provided feedback and contributed to the menu development.

Equipment for daily living and lifestyle supports were observed to be safe, suitable, clean and well maintained. Consumers said they had access to equipment, including mobility aids, to assist them with their daily living activities. Management and staff described the process for checking and cleaning equipment, and reporting any faults.

# 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. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service environment was open and welcoming. Consumers said they felt at home, the service was light-filled, easy to navigate, and maintained at a comfortable temperature for them. Consumers were supported to personalise their rooms and had access to courtyards, and balconies, including a purpose designed garden with a vintage car and raised garden beds for consumers within the memory support unit.

The Service was found non-compliant in Standard 5 in relation to Requirement 5(3)(b) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Areas within the service were accessible to all consumers, and consumers from the memory support unit were observed to be escorted by staff into the main courtyards for activities. Consumers and representatives expressed satisfaction with the cleanliness and maintenance of the service, and said they had free access both indoors and outdoors. The Assessment Team observed during the Site Audit, two chairs had laminated signs stating, ‘do not sit – chair broken’. Upon raising this with management, the service was responsive to the feedback and promptly removed one of the chairs, and advised the other chair was not broken, however the cushions were being cleaned, the cushions were replaced, and the sign removed.

Furniture, fittings, and equipment were safe, clean, well maintained, and suitable for consumers’ needs. Although the service had technical issues with the call bell system at the time of the Site Audit, consumers were provided handheld bells and pendants in the interim. In addition to the technical issues, the service increased the number of staff and number of observations to mitigate any risks to consumers. Staff described how shared equipment is cleaned, how they checked equipment safety and function, and how they reported maintenance requirements.

# 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

Consumers confirmed they were encouraged and supported to make complaints, provide feedback and had no issues talking with staff or management if they had a concern. Although the service had methods for consumers to make complaints and provide feedback including feedback forms, the Assessment Team found data from the service’s complaints register was not updated with the outcomes of those complaints. Management provided the Assessment Team, with the outcomes of those complaints on the second day of the Site Audit. This evidence is considered further in Requirement 8(3)(c).

The Service was found non-compliant in Standard 6 in relation to Requirement 6(3)(b) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives were aware of advocacy services available. Staff described how they would assist consumers who had a cognitive impairment or difficulty communicating to raise a complaint or provide feedback. Brochures and other written information in relation to advocacy and language services were displayed throughout the service.

Staff described the feedback and complaints-handling process and understood open disclosure and its’ underlying principles. Documentation reviewed, demonstrated and consumer feedback confirmed, the service acted in response to complaints and an open disclosure process was applied.

# Standard 7

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

Findings

Consumers and representatives considered staffing levels were adequate. Call bells were answered within the services key performance indicators of less than 10 minutes. The service had effective rostering processes, and staff said they had the resources to provide the right level of care to consumers.

Consumers and representatives said staff were kind, respectful, and professional in the way they conduct themselves. Observations of staff showed kind interactions between them and consumers as well as between themselves. The service required staff to sign and abide by a code of conduct which outlined behaviours that were acceptable whilst working for the organisation.

Consumers and representatives considered staff perform their duties effectively, and confident staff were trained appropriately, and skilled to meet their care needs. Position descriptions set out the expectations for each role and recruitment processes included verification of minimum qualification and registration requirements.

The Service was found non-compliant in Standard 7 in relation to Requirement 7(3)(d) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives felt confident staff were trained to provide the care and support they needed. The service had a local quality officer who supervised the development and delivery of training for staff. External expertise was used in specific areas, including dementia training. The service maintained clear and comprehensive logs of the training provided and required by staff.

The Service was found non-compliant in Standard 7 in relation to Requirement 7(3)(e) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. The service had a structured annual staff performance appraisal system, and provided feedback to staff following incidents, observations, or complaints. Staff confirmed they had received feedback through formal appraisals and ad-hoc discussions. A review of data showed systematic co-ordination of performance appraisals with high levels of engagement with members of the workforce.

# 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. | Compliant |

Findings

Consumers had a say in how their care and services were delivered, and felt their contributions were valued. Consumers and representatives were provided avenues for input, including during the pre-admission process, regular care planning and resident and representative meetings.

The organisation’s governing body displayed levels of engagement with the operations of the service. The service had open lines of communication across multiple divisions and the Board and sub-committees were provided updates on operational areas of the service. Although the service produced a monthly operational review report which included updates on consumers, staff, risk, compliance and finances to the Board, the Assessment Team found two reports were only a blank template. This evidence is explored further in Requirement 8(3)(c).

The Service was found non-compliant in Standard 8 in relation to Requirement 8(3)(c) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented some improvements to address the non‑compliance. However, not all of these improvements had been effective and I find the Service non-compliant with this Requirement and have provided evidence and reasoning below.

Regarding Requirement 8(3)(c), the Assessment Team considered the service had effective organisation-wide governance systems for managing financial and workforce governance, and the service was adhering to its regulatory requirements. The Assessment Team however found deficits relating to information management and continuous improvement.

**Regarding *information management***: The service was not effectively managing the recording, storing and distribution of information. During the Site Audit, information was requested and unable to be provided due to an inability to access the location where the information was stored. The service’s only staff member who had access to the requested information was absent during the Site Audit, and other information including call bell data could not be reported on due to technical issues.

Although the service used an online and paper based system to manage and store information, and consumers records were stored on the service’s ECMS, the Assessment Team found the complaints register was not available or accessible to the workforce due to the register being stored on an absent staff members computer. A hard copy of the complaint register was printed by that staff member prior to the Site Audit for the Assessment Team. The print-out contained data from 46 complaints made between 1 January 2022 and 26 September 2022. There were a total of 12 complaints which had no record of dates or actions taken, summaries of actions or listed as closed. The service provided updates on those 12 complaints during the Site Audit, however, was unable to provide an updated complaints register with complaints made since September 2022. In response, management included this deficit in the service’s plan for continuous improvement.

Evidence relied on under Requirement 8(3)(a) reflected the service historically held resident and representative meetings however, the Assessment Team found the most recent meeting documentation did not provide adequate information. The Assessment Team had requested a copy of the recent residents and representative meeting minutes and although the document provided was from the last meeting, there was no title or date indicated, who chaired it, or who provided the suggested activities listed. The minutes were not structured in a way that would have provided consumers and representatives with an overview of what was discussed.

The Approved Provider responded on 20 December 2022. Regarding information management, they acknowledged some deficiencies as identified by the Assessment Team and reported incorrect data sources were provided to the Assessment Team at the time of the Site Audit relevant to the Resident and Relative Meeting Minutes, and the service’s complaint register. Additionally, the response identified deficiencies relevant to information management were rectified following the Site Audit. However, as the service’s own governance systems had not identified the deficiencies, and not all members of the workforce had access to information, I therefore consider this is reflective of non-compliance with this item.

**Regarding *continuous improvement***: The service had a plan for continuous improvement that was monitored, updated and actions reviewed by the service’s quality team. At the time of the Site Audit, the plan for continuous improvement had items listed as work in progress, open or completed, however, not all items had dates. For example, an item for the organisation and decluttering of storerooms was listed as open, however, had no dates to indicate when the item was added or when the planned completion date would be.

The Approved Provider responded on 20 December 2022 and acknowledged the Assessment Team was provided a copy of the service’s Continuous Improvement Plan however the document was not the extended and detailed version. The Approved Provider submitted the extended plan, that detailed, descriptions of the issues, planned actions and dates for completion.

I acknowledge the organisation demonstrated some effective governance systems during the Site Audit supporting financial and workforce governance, regulatory compliance, feedback and complaints and continuous improvement, however, at the time of the Site Audit, deficits against information management had not been identified. Therefore, I find Requirement 8(3)(c) is non-compliant.

The service had a risk management system that included high impact and high prevalent risks, abuse or neglect of consumers, supporting consumers to live the best life they can and managing and preventing incidents. These systems, along with policies and procedures guided staff and supported consumers’ dignity of risk. Staff had been trained in their obligations to identify and respond to abuse and neglect.

The Service was found non-compliant in Standard 8 in relation to Requirement 8(3)(e) following a Site Audit in November 2020. Evidence in the Site Audit report dated 8 to 10 November 2022 supported the Service had implemented improvements to address the non-compliance and is now compliant with this Requirement. The clinical governance framework involved a set of leadership behaviours, policies, procedures and monitoring improvement mechanisms directed towards effective clinical outcomes. The service had adapted multiple strategies to assist the workforce to be educated across all areas of this Requirement, which were effective, with information displayed throughout the service, and with all staff demonstrating an understanding of the principles. The service maintained and regularly reviewed policies and procedures that covered open disclosure and minimising the use of restraint.

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