Halls Creek Peoples Church Frail Aged Hostel

Performance Report

440 Neighbour Street   
HALLS CREEK WA 6770  
Phone number: 08 9168 6524

**Commission ID:** 7178

**Provider name:** Halls Creek Peoples Church Incorporated

**Site Audit date:** 17 August 2021 to 19 August 2021

**Date of Performance Report:** 14 October 2021

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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 Approved Provider’s response to the Site Audit report received 6 October 2021
* the Performance Assessment Report for the Site Audit conducted on 15 to 17 September 2020
* the Performance Assessment Report for the Assessment Contact – Site conducted on 11 November 2020.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific Requirements have been assessed as Compliant.

The Assessment Team found overall, sampled consumers considered they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services, and live the life they choose. Sampled consumers and representatives provided the following feedback in relation to this Standard:

* Consumers reported they feel respected by staff, with some consumers providing specific examples of how staff show them respect.
* Consumers described things they do to maintain connections and relationships.
* Consumers provided examples of how staff are aware of their preferences.
* Two representatives indicated consumers’ information is kept private and confidential.

Staff interviewed demonstrated an awareness of consumers’ needs and preferences which supported respectful care and interactions. Staff were able to provide examples of how they support culturally safe care, including supporting consumers to feel connected to their community and maintaining relationships and friendships. Staff described strategies used to support consumers to take risks to enable them to engage in activities of their choosing. They also described strategies used to respect consumers’ privacy.

The service’s assessment and planning processes include gathering of information regarding consumers’ culture and life history. Care plans also include consumers’ next of kin and responsible persons in relation to making decisions. Risk mitigation strategies in relation to risky activities are included in care plans, with staff guided to support consumers through the service’s policies and procedures. While the service has a lifestyle program, it is not used and is not related to consumers’ preferences or choices which support promotion of emotional, spiritual and psychological well-being (please refer to Standard 4 Services and support for daily living).

The Assessment Team observed staff speaking with consumers in a respectful manner. They also observed consumers’ personal information to be kept confidential and staff maintaining consumers’ privacy during provision of care.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant as five of the five specific Requirements have been assessed as Compliant.

The Assessment Team found overall, sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. Sampled consumers and representatives provided the following feedback in relation to this Standard:

* Four consumers indicated they tell staff what they want daily and one consumer said their family are involved in their care planning.
* Consumers were generally satisfied with the care provided.

The service has assessment and care planning processes which includes a range of assessments completed by clinical staff at least annually or as required to develop care plans, with reviews conducted every six months. Care plans include consumers’ preferences and mostly identify goals. While most consumers’ files sampled do not include advance care planning, staff reported this is in accordance with consumers’ wishes, however, opportunities to discuss these preferences are included in family conferences. Additionally, the service uses a ‘resident of the day’ process each month to monitor consumer care outcomes.

Sampled care plans demonstrated families are involved in assessment and planning, with other health professionals and organisations included where necessary. They also demonstrated referrals are made where necessary and assessments are completed annually and as required.

Staff interviewed indicated care plans are readily available and assessments are completed by clinical staff. Other information available for staff was included in daily handover sheets, daily care alerts and ‘resident of the day’ documents.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with all Requirements in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Compliant as seven of the seven specific Requirements have been assessed as Compliant.

Following an Assessment Contact – Site on 11 November 2021, Requirement (3)(a) was found to be Non-compliant because the service was unable to demonstrate that each consumer was receiving personal care, including showering, toileting assistance, continence care, assistance with transfers and mobility or meals and drinks in accordance with their assessed needs which impacted upon consumers’ health and well-being. Based on the Assessment Team’s report and the Approved Provider’s response I find this Requirement to be Compliant. I have provided reasons for my finding in the respective Requirement below.

In relation to all other Requirements, the Assessment Team found overall, sampled consumers considered that they received personal care and clinical care which is safe and right for them. Sampled consumers and representatives provided the following feedback in relation to this Standard:

* Three consumers and one representative interviewed confirmed consumers receive personal care and clinical care which is safe and right for them.
* Four consumers indicated clinical staff review them when they are feeling unwell.
* All consumers indicated staff know how to care for them.

The service uses clinical assessments to identify consumers with high impact or high prevalence risks associated with their care, specifically, consumer files sampled in relation to wound care demonstrated effective management.

Staff interviewed were aware of consumers’ clinical care needs and strategies used to manage risks associated with this care. Consumers’ care needs are communicated through care alerts, handover and handover sheets. Staff have access to care plans to support provision of care. They also indicated they have access to adequate personal protective equipment to minimise spread of infection.

A sampled consumer’s file who received palliative care demonstrated there was a case conference with the consumer’s family to understand end of life wishes. Two sampled consumers’ files indicated staff identify and respond to changes in consumers’ conditions. Sampled consumer files also demonstrated consumers are referred to relevant health specialists as required and are regularly reviewed by allied health professionals. The service maintains a register of infections and monitors antibiotic usage.

The Assessment Team observed clinical staff reviewing a consumer’s clinical care needs with the medical officer. They also observed a consumer being assisted to be taken to a health specialist appointment.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with all Requirements in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*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.*

This Requirement was found to be Non-compliant following an Assessment Contact – Site, conducted on 11 November 2020. It was found the service was unable to demonstrate that each consumer was receiving personal care, including showering, toileting assistance, continence care, assistance with transfer and mobility or meals and drinks in accordance with their assessed needs which impacted upon consumers’ health and well-being. The Assessment Team found an improvement plan was developed to address these deficiencies and actions are in progress. These actions include:

* Recent employment of three staff to provide assistance to consumers in relation to personal care, providing a mix of both male and female staff to support consumers’ preferences.
  + The Assessment Team found consumers are provided showers three times a week and are assisted with a wash on other days, with no consumers having skin rashes or impairments due to insufficient personal care or toileting. There were also no consumers who were identified with weight loss or dehydration due to not being assisted with meals.
  + Staff interviewed reported an improvement in relation to staffing numbers to provide personal care.
* The Assessment Team provided the further information and evidence which is relevant to my finding:
* Sampled consumers’ files, inclusive of assessments, care plans and progress notes demonstrated overall, consumers’ care is safe, effective and tailored to their needs.
  + Restrictive practices in relation to physical and chemical restraint are being used but these are being actively monitored and reviewed. However, for one consumer who is administered psychotropic medications to support the management of agitation, the service has not undertaken any pain monitoring charts to identify if the agitation is related to pain. However, the Assessment Team found pain assessments and monitoring charts are conducted annually and as required, with observations and progress notes indicating consumers’ pain is managed.
  + One consumer’s skin assessment identified the requirement for a specialised mattress due to their high risk of skin impairment and wounds but this had not been provided. However, the Assessment Team did not find any concerns in relation to consumer’s skin integrity.
  + The Approved Provider’s response indicated pain charting for this consumer has commenced, as well an air mattress being implemented.
* Three consumers and one representative interviewed confirmed consumers receive personal care and clinical care which is safe and right for them.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with Requirements (3)(a) in Standard 3 Personal care and clinical care.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Non-compliant as two of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(b) and (3)(c) in this Standard as not met. Requirement (3)(c) was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020 because the service was unable to demonstrate consumers were supported and assisted to participate in activities of interest within the service. Based on the Assessment Team’s report and the Approved Provider’s response I find Requirements (3)(b) and (3)(c) to be Non-compliant. I have provided reasons for my finding in the respective Requirements below.

In relation to Requirements (3)(a), (3)(d), (3)(e), (3)(f) and (3)(g) in this Standard, some consumers interviewed consider they get the services and supports for daily living which are important for their health and well-being and that enable them to do things they want to do. Examples and comments from consumers include:

* Three consumers indicated they are supported by the service in their daily needs.
* One consumer described how they get support from an external organisation.
* Seven consumers indicated they liked the food.

Staff interviewed were familiar with consumers’ lifestyle preferences and demonstrated an attitude of supporting consumer choices and preferences. They also indicated other organisations assist consumers at the service with daily living support.

The service’s assessment and planning processes include a leisure and lifestyle assessment which identifies consumers’ lifestyle preferences, including dietary needs and preferences, and is used to develop a lifestyle plan. The service has a referral process to other organisations and consumer files sampled indicated referrals had occurred. The service uses a four-weekly rotating menu in relation to meals and will do their best to vary meals based on supplies.

The Assessment Team observed consumers to be provided with morning and afternoon tea and found equipment to be clean and well maintained.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with Requirements (3)(a), (3)(d), (3)(e) (3)(f) and (3)(g) in Standard 4 Services and support daily living.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Non-compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The Assessment Team found the service was unable to demonstrate that services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. The Assessment Team provided the following evidence and information relevant to my finding:

* While assessment processes identify consumers’ emotional and spiritual needs and this information is used to develop care plans, these needs and preferences are not being met by staff.
  + A consumer’s (Consumer A) assessment and activity records demonstrate the consumer has not been supported to attend church services or provided one-to-one emotional support chats in a three-month period. Progress notes indicate minimal social and emotional support, with the consumer feeling quite lonely at times and missing family. The Assessment Team spoke with Consumer A’s family who were of the view the service would take the consumer out more. The Assessment Team interviewed Consumer A who expressed sadness and was observed to have minimal interaction with staff in relation to emotional support.
  + A consumer’s (Consumer B) assessment and activity records demonstrates the consumer has not been supported to attend church for three months and activity preferences are not always met. The Assessment Team observed Consumer B to have minimal staff engagement and was not engaged in television or preferred leisure activities identified in their care plan. Staff interviewed were aware of the consumer’s emotional support strategies but indicated these are currently unable to be implemented.
  + A consumer’s (Consumer C) assessment and activity records demonstrates the consumer has not been supported to attend church/have pastoral care for three months and minimal occasions where other emotional support strategies have been implemented. The Assessment Team observed Consumer C to remain in their room each day of the Site Audit with no interventions provided to support emotional support.
* While the service has a lifestyle program, it is not used and is not related to consumers’ preferences or choices which support promotion of emotional, spiritual or psychological well-being.
  + Activity records for five consumers had an activity identified as being completed, however, observations by the Assessment Team indicated this has not been completed, nor supported connectedness or emotional support. Additionally, progress notes and an interview with one consumer indicated their activity records, while showing as activities of preference to have been provided, these had not occurred.

The Approved Provider submitted a response to the Assessment Team’s report, indicating the service continues to work hard under very difficult circumstances due to staffing issues associated with the remote location of the service and the manager’s unplanned leave. The Approved Provider submitted the following information and evidence relevant to my finding:

* Staff shortages have been an ongoing issue and while recruitment strategies are being used, these are not resulting in the engagement or retention of suitably qualified staff.
* The previous manager has been appointed to provide ongoing management support and the Approved Provider is networking with other providers who are experiencing similar recruitment issues.
* Engagement of pastoral support and cultural and psychological support will be provided by the Halls Creek arts centre.
* The use of the facility bus is not a contentious issue but was not communicated well to staff and priority use of the bus by consumers is supported by the Board.
* Consultation with the National Disability Insurance Scheme for relevant consumers to strengthen support services and there has been an improvement since the Site Audit.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the difficulties experienced by the Approved Provider in recruiting and retaining staff and the actions taken in response to the deficiencies identified. However, I find the service has not demonstrated that each consumer is supported and provided with active and regular services/support to promote spiritual, psychological or emotional well-being. I have considered that Consumers A, B and C have had specific needs, preferences and strategies identified to support to their emotional, spiritual and psychological needs but these strategies have either not been implemented or only implemented seldomly, or in an ad hoc manner. Additionally, activity records are not always reflective of actual supports provided which will inhibit the effective monitoring and reviewing of services and supports required to meets consumers’ needs.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirement (3)(b) in Standard 4 Services and support for daily living.

### Requirement 4(3)(c) Non-compliant

*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.*

This Requirement was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020. It was found the service was unable to demonstrate consumers were supported and assisted to participate in activities of interest within the service. The Assessment Team found an improvement plan was developed to address these deficiencies and actions are in progress. These actions include:

* The service’s vehicles were re-registered and are being maintained to support consumers with external outings into the community.
* Administration, maintenance and the relief manager were assisting with lifestyle activities, including transportation for outings. However, this is no longer occurring, with maintenance staff only taking some consumers out if they require some maintenance items.

The Assessment Team found improvements had not resulted in supporting consumers to participate in activities of interest to them. The Assessment Team provided the following evidence and information relevant to my finding:

* Four consumers identified in the September 2020 Site Audit report have not been supported with their nominated interests or things which are important to them.
  + These four consumers’ assessments and activity records demonstrate these consumers have not or have seldomly participated in activities of interest to them. Two of these four consumers were observed during the Site Audit to not be supported to engage in their activities of preference.
  + An additional two consumers and their assessments were reviewed, care plans and activity records demonstrated the consumers have not been supported to engage in activities of preference. Observations by the Assessment Team confirmed the consumers were not supported to actively engage in their interests.
* While an audit was conducted in March 2021 to identify lifestyle activities which were most important to consumers, this information has not been used, including consumers’ expressed interest in external activities.

The Approved Provider submitted a response to the Assessment Team’s report, indicating the service continues to work hard under very difficult circumstances due to staffing issues associated with the remote location of the service and the manager’s unplanned leave. The Approved Provider submitted the following information and evidence relevant to my finding:

* Staff shortages have been an ongoing issue and while recruitment strategies are being used, these are not resulting in the engagement or retention of suitably qualified staff.
* The use of the facility bus is not a contentious issue but was not communication well to staff and priority use of the bus by consumers is supported by the Board.
* Consultation with the National Disability Insurance Scheme for relevant consumers to strengthen support services and there has been an improvement since the Site Audit.
* While the service had engaged an Indigenous female coordinator for community support programs for elder women, unfortunately no services were provided.
* Due to COVID-19, the inter-generational schools’ program was unable to continue and pastoral support has also been impacted.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the difficulties experienced by the Approved Provider in recruiting and retaining staff and the actions taken in response to the deficiencies identified. However, I find the service has not demonstrated that services and supports for daily living assist each consumer to participate in their community within and outside the service environment, have social and personal relationships and do the things of interest to them. I have considered that consumers identified in the previous Site Audit report as not having their needs met in relation this Requirement and additional consumers, were all identified as having their needs and preferences not being met. I have relied upon the Assessment Team’s observations, interviews and activity records which demonstrate consumers are not meaningfully engaged in activities of interest to them, nor are they supported to routinely attend activities and engagements outside of the service. Additionally, I have considered services and supports identified directly relate to consumers having social and personal relationships, however, these supports and services are not effectively implemented to support the nurturing of these relationships.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirements (3)(c) in Standard 4 Services and support for daily living.

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific Requirements have been assessed as Compliant.

The Assessment Team found overall, sampled consumers consider they feel they belong in the service and feel safe and comfortable in the service environment. Sampled consumers and representatives provided the following feedback in relation to this Standard:

* They felt comfortable in the service and provided examples of how the service environment is suitable for consumers’ preferences.
  + However, two consumers indicated they were unable to operate the heating system in their room and felt cold at night. The Approved Provider’s response indicated all consumers’ comfort has been assessed and was scheduled for review at the next resident meeting.

The Assessment Team observed the service environment to be welcoming and allowed consumers to freely move around the service. Consumers’ rooms were observed to be personalised and appeared comfortable, with access to internal and external communal living environments. The service environment appears to be mostly safe, clean and well maintained, however, the Assessment Team did observe the opportunity for additional cleaning. Most furniture, fittings and equipment were observed to be safe, clean and well maintained and suitable for consumers. However, some adjustable bed heights were reported by staff to not be working and the Approved Provider is waiting for confirmation of quotes to repair the beds.

Staff interviewed described maintenance processes used to address ad hoc issues and regular maintenance tasks undertaken, including the use of external contractors to support these processes. However, documentation to support these processes was unable to be provided. The Approved Provider’s response indicated the documentation has been replaced. Management provided examples of changes to the service environment based on security and safety risks. Staff indicated they have sufficient and suitable equipment to support them to conduct their roles but were concerned they only have one hoist which may present a problem if it broke down and that air mattresses were not always working. The Approved Provider indicated a second hoist to assist consumers with transfers has been purchased and new air mattresses ordered.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Non-compliant as one of the four specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(d) in this Standard as not met. The Assessment Team found the service was unable to demonstrate that it uses feedback and complaints to improve the quality of care and services. Based on the Assessment Team’s report and the Approved Provider’s response, I find this Requirement to be Non-compliant. I have provided reasons for my finding in the respective Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers are encouraged and supported to provide feedback and make complaints. Staff interviewed were able to describe how they report comments or concerns from consumers, however, management indicated no feedback or complaints from consumers have been received.

The service has a feedback and complaints policy which indicates the service is to establish a system to manage and encourage feedback and complaints. Meeting minutes for a quality meeting which was attended by seven consumers included feedback and complaints as standing agenda item but no issues were raised. The resident handbook contained information relating to feedback forms, external complaints avenues and advocacy services.

The service has an open disclosure policy but there have been no recent complaints or incidents which have required the use of open disclosure.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with Requirements (3)(a), (3)(b) and (3)(c) in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team found the service was unable to demonstrate that it uses feedback and complaints to improve the quality of care and services. The Assessment Team provided the following evidence and information relevant to my finding:

* The service has not used information gathered from a lifestyle survey conducted in March 2021 to improve the quality of services and supports for daily living to support consumer needs and preferences.
  + The manager was unaware of the actions identified following this survey, including contacting an external community group to support consumers.
* The Assessment Team was not provided with a recent central register for feedback and complaints because management stated there have been no complaints or feedback.

The Approved Provider submitted a response to the Assessment Team’s report indicating the service have considered improvements. The Approved Provider submitted the following information and evidence relevant to my finding:

* Most consumers provide verbal feedback and complaints and due to personal and cultural reasons will avoid confrontation.
* The resident survey has been revised to be more easily administered with language which is more culturally appropriate.
* Consideration of re-introducing a revised format of an information tea/resident meeting where insights of consumers can be captured.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the difficulties experienced by the Approved Provider in recruiting and retaining staff and the actions taken in response to the deficiencies identified. However, I find the service has not demonstrated that they use feedback and complaints to improve the quality of care and services. I have considered actions in the form of a survey were taken in response to deficits identified in Standard 4 following the Site Audit in September 2020. While this process highlighted relevant feedback to support consumers’ social, emotional and engagement in activities of interest, it has not been used to improve services and supports. Additionally, while the Approved Provider indicates consumers will provide feedback verbally, processes to support this have not been proactive to understand consumer views and actions to do so have only been considered following the most recent Site Audit.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(a) and (3)(d) in this Standard as not met. Requirement (3)(a) was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020 because the service was unable to demonstrate sufficient numbers of staff to ensure the delivery and management of safe and quality care and services. Based on the Assessment Team’s report and the Approved Provider’s response I find Requirements (3)(a) and (3)(d) to be Non-compliant. I have provided reasons for my finding in the respective Requirements below.

In relation to Requirements (3)(b), (3)(c) and (3)(e) in this Standard, most consumers interviewed considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. Specific comments from consumers included:

* Staff are kind and caring and were generally satisfied with the provision of care.
* They can access clinical staff when they are not feeling well.
* They feel that staff know what they are doing.

The Assessment Team observed staff speaking with consumers in their preferred language and to be using respectful body language. They also observed interactions between staff and consumers to be kind and respectful.

The service maintains records in relation to registrations of clinical staff and management indicated they monitor staff practices through observations, feedback processes and staff performance appraisals. The service has implemented a new appraisal schedule and a clinical staff member interviewed confirmed they have participated in a performance assessment.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with Requirements (3)(b), (3)(c) and (3)(e) in Standard 7 Human resources.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*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.*

This Requirement was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020. It was found the service was unable to demonstrate sufficient numbers of staff to ensure the delivery and management of safe and quality care and services. The Assessment Team found an improvement plan was developed to address these deficiencies and actions are in progress. While improvements had been made to care staff numbers, the Assessment Team found the service was unable to demonstrate improvements have been maintained. The Assessment Team provided the following information and evidence relevant to my finding:

* The service manager has been in the position for five months but is only working four days per week (reduced hours), resulting in reduced oversight of the service.
* The service manager stated that while three staff members have been recruited, care staff not working their rostered shifts continues to be an ongoing problem.
* The Assessment Team observed the floors in consumers’ rooms, bathroom area and toilets required additional cleaning. The service manager stated there was no formal cleaner at the service.
* The Assessment Team found several consumers have not been supported to engage in meaningful activities through the progress notes, observations and interview with a consumer (see Standard 4 Requirements (3)(b) and (3)(c) for detailed evidence). The service manager confirmed the service does not have an activity coordinator.
* The Assessment Team found rosters were not always being staffed accordingly, with care staff shifts regularly not being filled.
  + The Assessment Team observed several consumers’ fingernails to be dirty and uncut.
* Clinical staff assist with consumers’ personal care when care staff cannot attend their rostered shifts, however, female consumers indicated they were unhappy they were not receiving care from care staff of their preferred gender because all clinical staff are male.
* Staff interviewed confirmed they were undertaking tasks outside of their responsibilities which impacted on the provision of care and services.

The Approved Provider submitted a response to the Assessment Team’s report, indicating the service continues to work hard under very difficult circumstances due to staffing issues associated with the remote location of the service and the manager’s unplanned leave. The Approved Provider submitted the following information and evidence relevant to my finding:

* The COVID-19 pandemic has resulted in border restrictions which has exacerbated the staffing concerns.
* The Approved Provider continues to recruit for vacancies and this includes recruitment of two registered nurses with a preference for females.
* A new cleaner has been appointed.
* The cultural concerns relating to gender of staff providing personal care due to lack of female clinical staff has been noted.
* Consumers’ nails have been discussed with clinical staff who will strengthen the ‘resident of the day’ process.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the difficulties experienced by the Approved Provider in recruiting and retaining staff and the actions taken in response to the deficiencies identified. However, I find the service has not demonstrated that staffing levels and mixes have supported the delivery of quality care and services. I have considered the Assessment Team’s findings in relation to consumers not being supported to engage in meaningful activities, observations of the living environment requiring further cleaning and consumers’ grooming presentation of their fingernails. I have also considered consumers indicated they do not have their personal preferences met in relation to personal care due to staffing issues and staff/management interviewed confirmed staffing rosters are not filled, with several care and clinical shifts not adequately filled.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirement (3)(a) in Standard 7 Human resources.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team found the service was unable to demonstrate the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. The Assessment Team provided the following evidence and information relevant to my finding:

* Eleven of 26 staff are not up-to-date with mandatory training/education.
* Clinical and care staff interviewed were not aware of their role in relation to the Serious Incident Response Scheme (SIRS).
* The loss of the local TAFE trainer was identified at the Assessment Contact in November 2020 and no further plans have been progressed to support staff to complete their Certificate III in Aged Care or new staff having the opportunity to commence this Certificate.

The Approved Provider submitted a response to the Assessment Team’s report indicating the service has considered improvements. The Approved Provider submitted the following information and evidence relevant to my finding:

* The Approved Provider has been in regular contact with TAFE Broome to provide training in relation to Certificate III but it is difficult to obtain onsite support for a small provider. However, TAFE Broome are scheduled for an onsite visit in relation Certificate III for three current staff members.
* SIRS training has been scheduled for all staff and the Board. Mandatory training has commenced.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the difficulties experienced by the Approved Provider in recruiting and retaining staff and the actions taken in response to the deficiencies identified. However, I find the service has not demonstrated that staff are supported and trained to deliver care and services in accordance with the Quality Standards. I have considered that staff are not up-to-date with routine mandatory training and that staff interviewed are not able to explain their role in relation to SIRS.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirement (3)(d) in Standard 7 Human resources.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(c) and (3)(d) in this Standard as not met. Requirement (3)(c) was found to be Non-complaint following the Site Audit conducted on 15 to 17 September 2021 because the service was unable to demonstrate effective governance systems in relation to regulatory compliance or workforce governance. At this Site Audit, the Assessment Team found the organisation was unable to demonstrate effective governance systems in relation to workforce governance, continuous improvement and regulatory compliance. They also found the service was unable to demonstrate effective risk management systems and practices, specifically in relation to managing high impact or high prevalence risks associated with the care of consumers and identifying and responding to abuse and neglect of consumers and use of an incident management system. Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirements (3)(c) and (3)(d) to be Non-compliant. I have provided reasons for my finding in the respective Requirements below.

In relation to Requirement (3)(b) in this Standard, this Requirement was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020 because the service was unable to demonstrate the governing body, the Board, promoted a culture of safe, inclusive and quality care or was accountable for the delivery of care and services. Based on the Assessment Team’s report and the Approved Provider’s response, I find this Requirement to be Compliant. I have provided reasons for my finding in the respective Requirement below.

In relation to Requirements (3)(a) and (3)(e) in this Standard, the Assessment Team found the organisation demonstrated that consumers are engaged in the development, delivery and evaluation of care through formation and review of care plans, participating in meetings and encouragement to provide feedback. The Assessment Team also found the service has an effective clinical governance framework, inclusive of policies and procedures relating to antimicrobial stewardship, minimisation of the use of restraint and the use of open disclosure. Staff interviewed were able to provide examples of how the clinical governance policies and procedures relate to their work.

Based on the information and evidence in the Assessment Team’s report and the Approved Provider’s response, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with Requirements (3)(a) and (3)(e) in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

This Requirement was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020. It was found the service was unable to demonstrate the governing body, the Board, promoted a culture of safe, inclusive and quality care or was accountable for the delivery of care and services. To address the deficiencies identified, a sub-committee of the larger Peoples Church Board was formed in 2020 to enable members of the committee to focus on the governance of the residential service. Additionally, there is now a planned schedule for monthly sub-committee meetings with monthly performance reports from the service manager as a standing agenda item.

* At this Site Audit in August 2021, the Assessment Team found the organisation demonstrated it promotes a culture of safe, inclusive and quality care and services. The Assessment Team provided the further information and evidence which is relevant to my finding:
* A Board member interviewed stated the Board has engaged the former relief facility manager as an advisor to the Board, including reporting of incidents and raising issues of concern and the Chair of the Board regularly communicating with the service manager.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Compliant with Requirement (3)(b) in Standard 8 Organisational governance.

### Requirement 8(3)(c) Non-compliant

*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.*

This Requirement was found to be Non-compliant following a Site Audit conducted on 15 to 17 September 2020. It was found the service was unable to demonstrate effective governance systems in relation to regulatory compliance or workforce governance. While the organisation has been provided time to address these deficiencies, at this Site Audit in August 2021, the Assessment Team found the organisation was unable to demonstrate effective governance systems in relation to workforce governance, continuous improvement or regulatory compliance.

The Assessment Team provided the further information and evidence which is relevant to my finding:

* In relation to workforce governance, the service was unable to demonstrate it had been able to maintain the number and mix of staff to enable the delivery of quality care and services. The Assessment Team found this impacted on quality outcomes for consumers, including being engaged in meaningful activities and provision of personal care.
* In relation to regulatory compliance, the service has not ensured all Board members and staff have a current police clearance/checks or evidence that staff have had influenza vaccinations in accordance with legislative requirements. Additionally, the Board, management and staff have not received training in relation to the Serious Incident Response Scheme (SIRS). An audit in relation to regulatory compliance was completed in July 2021 but the findings did not identify the deficiencies identified by the Assessment Team.
* In relation to continuous improvement, while the organisation has a plan for continuous improvement, it does not contain measurable outcomes or plans for evaluation of improvements.

The Approved Provider submitted a response to the Assessment Team’s report, indicating the service continues to work hard under very difficult circumstances due to staffing issues associated with the remote location of the service and the manager’s unplanned leave. The Approved Provider submitted the following information and evidence relevant to my finding:

* The acting administration manager has contacted all staff and the Board to ensure police clearances are up-to-date.
* The acting administration manager has contacted all staff to ensure influenza vaccinations are up-to-date.
* SIRS training for staff and the Board has been arranged.
* The continuous improvement plan is being reviewed an updated.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the difficulties experienced by the Approved Provider in recruiting and retaining staff, including for management roles. I also acknowledge that there are effective governance systems in relation to financial governance, information management and feedback and complaints. However, I find the service has not demonstrated effective governance systems in relation to regulatory compliance, workforce governance and continuous improvement.

I have considered that the organisation has not ensured its Board members or staff are complying with relevant legislation in relation to police clearances and vaccinations and that its monitoring processes in relation to regulatory compliance have been ineffective in identifying these deficiencies.

I have also considered the ongoing nature of the staffing issues which have not been rectified, including effective processes to support and develop its workforce. I acknowledge the difficulties the Approved Provider must manage due to the location of the service but find workforce governance processes have not been effective in ensuring staffing roles and shifts are appropriately filled and staff supported with relevant education and training.

While I acknowledge the service has a continuous improvement plan, I have considered the plan does not contain measurable outcomes or plans for evaluation of improvements which inhibits effective evaluation and review processes.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### Requirement 8(3)(d) Non-compliant

*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.*

The Assessment Team found the service was unable to demonstrate effective risk management systems and practices, specifically in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers and use of an incident management system. The Assessment Team provided the following evidence and information relevant to my finding:

* Management was unable to describe processes used to identify, monitor and manage consumers with high impact or high prevalence risks associated with their care. Additionally, they were unable to identify consumers with high impact or high prevalence risks associated with their care.
* Staff are not up-to-date with their mandatory training, which includes elder abuse and mandatory reporting.
* Interviews with management, staff and the Board indicated the service does not have an effective incident management system and none have completed SIRS training or education. Management indicated there had been no incidents, however, an incident folder demonstrated there had been nine incidents in a five month period. Additionally, there were no examples of trending and analysis of incidents or examples of incident reviews which have led to improvements.

The Approved Provider submitted a response to the Assessment Team’s report. The Approved Provider submitted the following information and evidence relevant to my finding:

* The risk management system and the incident reporting system and management procedure have been reviewed and updated.
* Clinical staff have participated in education sessions relating to clinical care practices.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be Non-compliant with this Requirement.

In coming to my finding, I acknowledge the actions taken by the Approved Provider to address deficiencies associated with this Requirement. However, I find the service was unable to demonstrate effective risk management systems and practices. I have relied upon the absence of processes and practices to support the identification, monitoring and management of high impact or high prevalence risks associated with the care of consumers. I have also considered the lack of training and support in relation to elder abuse and SIRS to support effective management of responding to abuse and neglect and incident management. Additionally, I have considered the incident management system has not been effective in relation to preventing incidents through the absence of trending and analysis and management’s lack of knowledge regarding incidents.

For the reasons detailed above, I find Halls Creek Peoples Church Incorporated, in relation to Halls Creek Peoples Church Frail Aged Hostel, to be Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### Requirement 8(3)(e) Compliant

*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.*

# 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.

The service has implemented an action plan to address the deficiencies identified by the Assessment Team and has included improvements which directly address the issues identified by the Assessment Team in the relevant Requirements.

The service should seek to ensure the following:

* **Standard 4 Requirements (3)(b) and (3)(c):**
  + Strategies and interventions to support consumers’ assessed emotional, psychological and spiritual needs are effectively implemented.
  + Consumers are supported to engage in meaningful activities, including those identified through assessment processes and to continue to participate in the community, both inside and outside of the service.
  + Monitoring processes effectively record and evaluate activities engaged in, including levels of participation and enjoyment.
* **Standard 6 Requirement (3)(d):**
  + Use feedback from consumers to improve the service’s quality of care and services.
  + Provide consumers with opportunities to provide feedback in relation to the overall quality of care and services.
* **Standard 7 Requirements (3)(a) and (3)(d):**
  + Staffing levels and mixes support the provision of safe and quality care and services, specifically to meet the needs of the current consumer cohort.
  + Staff are supported and effectively trained in their roles.
* **Standard 8 Requirements (3)(c) and (3)(d):**
  + Legislative responsibilities are met and monitored in relation to police clearance and vaccinations.
  + The workforce is planned to ensure staff have the skills and knowledge and there are appropriate numbers of staff and mix to deliver care and services in accordance with the Aged Care Quality Standards, including considerations for occasions when key personnel are not available.
  + Continuous improvement processes include effective evaluation and review.
  + The risk management system effectively guides staff practices and staff are made aware of their roles in implementing these practices and processes.