Hopevale Aged Hostel

Performance Report

Corner Thiele & Thuppi Street
HOPE VALE QLD 4895
Phone number: 07 4060 9242 / 0498 855 817

**Commission ID:** 5177

**Provider name:** Hope Vale Aboriginal Council

**Site Audit date:** 12 -14 October 2021

**Date of Performance Report:** 10 November 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** | **Non-compliant** |
| Requirement 2(3)(a) | Non-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** | **Non-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) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | 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** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | 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) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-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 provider’s response to the Site Audit report received 8 November 2021
* other information and relevant matter held by the Commission in relation to the service.

# 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

Consumers and reperesentatives felt consumers were treated with dignity and respect, care and services were culturally safe, and their identity, culture and diversity was valued. They confirmed consumers were supported to make decisions about their care and services, who they preferred to be involved in their care and relationships they chose to maintain.

Consumers said they understood information by the service in relation to their care and services and they felt supported to exercise choice. They confirmed their privacy was respected by staff and their confidential information was protected.

Care documentation reflected strategies employed by staff to ensure care delivered was culturally safe and met the diverse needs of consumers. Contact information for representatives and the primary contacts of consumers was recorded in care planning information.

The service supported consumers to take risks to enable them to live they best life they could including, but not limited to, community relationships, smoking, nutrition and mobility.

Staff spoke about consumers in a respectful and dignified manner and demonstrated a shared understanding of the individual identity, diversity, culture and life journeys of consumers. Staff supported consumers to make informed decisions about their care and services and maintain relationships with those important to them. Staff supported consumers to take risks to enable them to live the best life they could including, but not limited to, community relationships, smoking, nutrition and mobility.

Information provided to consumers in relation to their care and services was generally provided through consumer and representative meetings, activity calendars and discussions with management and staff. Staff employed strategies to ensure consumers’ privacy was respected which included knocking on consumer’s doors, obtaining consent prior to the provision of care, closing doors and curtains and discussing and sharing consumer information in private areas of the service.

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

## 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 NON-COMPLIANTOngoing 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

Consumers and representatives were not consistently consulted regarding the risks associated with the care of consumers.

The service did not have behaviour support plan templates available to demonstrate compliance with legislative requirements in relation to behaviour management and restrictive practices. Assessments for the safe use of restrictive practices, smoking management and swallowing deficiencies of consumers had not been completed.

Management acknowledged that assessments were not reviewed regularly including when consumers were discharged from hospital or when changes in their care needs were identified.

Risk management strategies were not reflected in care plan information. Risks to the health and well-being of consumers were not reviewed regularly, or in response to the changed care needs of consumers. The service’s assessment tools were not current or reflective of best practice.

Policies and procedures relevant to this standard were not current or available to staff to guide their practice.

While the service had not assessed risks in relation to restrictive practices, smoking and swallowing deficiencies, consumers and representatives said they were generally involved in the assessment and ongoing planning of care for consumers.

Some consumers said staff had discussed their end of life preferences with them and confirmed staff knew what they were doing and delivered care to meet their individual needs and preferences. Consumers and representatives said staff had discussed information in their care plan which was reviewed when the needs of consumes had changed or when incidents had occurred.

Staff generally demonstrated a shared understanding of the individual risks to the health and well-being of consumers. Care staff understood the individual preferences of consumers and provided examples of how these were supported. The Facility manager/Registered nurse was responsible for the initiation of referrals which were completed in a timely manner.

Care documentation generally reflected consumers’ needs, goals and preferences including advance care and end of life planning. Care planning information reflected the involvement of the Medical officer and allied health professionals in assessment and planning processes. Care and service plans were generally reviewed when the circumstances of consumers had changed or in response to incidents.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-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.*

Consumers and representatives said the service’s assessment and planning processes resulted in consumers receiving the care they needed. However, the representative for a named consumer confirmed the risks associated with the implementation of a low low bed/restrictive practice and dietary preferences had not been discussed with them.

While care and service plans were reviewed in response to changes in the condition of consumers, assessments were not reviewed regularly, including when consumers returned from hospital or when their care needs changed. Care documentation did not reflect assessments or behaviour support plans had been completed for the use of a mechanical restraint in line with legislative requirements. Assessment tools were not current and did not reflect clinical best practice.

The approved provider in its response received 8 November 2021, has planned actions to address the deficiencies identified in relation to restrictive practices and the risks associated with the named consumer’s dietary preferences. These include consultation with the named consumer’s Enduring Power of Attorney to discuss the risks and obtaining informed consent for the use of the mechanical restraint. Care plan information will reflect the us of the restrictive practice, a behaviour support plan will be sourced from an external peak aged care peak body advisory group and implemented to support staff in the delivery of safe and effective care. Further to this, the named consumer will be reviewed by a Speech pathologist to ensure the risks associated with their dietary preferences are assessed, discussed and recorded. Dietary plan information and the pending Speech pathologist review has been discussed with the consumer.

A smoking assessment was not completed for a named consumer who chose to smoke. Care information did not evidence the identification of potential risks associated with smoking to support staff in the delivery of safe and effective care.

The approved provider in their response has included improvement actions to address deficiencies identified by the Assessment Team. These include the completion of a smoking assessment for the named consumer who chose to smoke, education with the named consumer to discuss the risks associated with smoking and the use of oxygen. Further to this, smoking assessments will be completed for all consumers who smoke upon entering the service.

During the site audit, management acknowledged the deficiencies identified by the Assessment Team and advised actions would be taken to rectify them including, consultation with the named consumer’s representative in relation to the risks associated with the mechanical restraint and their dietary preferences. Clinical assessment tools, restrictive practice authorisation forms and behaviour support plans for consumers subjected to restrictive practices will be sourced and completed to ensure the approved provider’s legislative responsibilities are met.

I acknowledge the improvements planned by the approved provider to address the deficiencies identified by the Assessment Team however, at the time of the site audit, assessment and planning did not include the considertation of risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services.

Therefore, it is my decision this Requirement is Non-compliant.

### 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 NON-COMPLIANTPersonal 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 service’s infection control practices and preparedness to support the management and prevention of a potential COVID-19 outbreak were not effective. Risk screening processes were not monitored and failed to identify vistors and contractors poor compliance with Queensland Government Residential Aged care directions and Commonwealth Government requirements. Management did no have a shared understanding of current personal protective equipment requirements for visitors.

While the service was unable to demonstrate processes to minimise infection related risks were effective, consumers and representatives spoke highly of staff and said they were satisfied with the care and services they received.

Consumers and representatives felt the needs of consumers were effectively communicated between staff and staff were familiar with their individual preferences. They confirmed consumers could access a Medical officer or other health professionals when required. Consumers and representatives reported being consulted and involved in decisions regarding their care and services.

Staff said they could access information they needed to provide safe and effective care and could escalate concerns to registered staff if required. Staff had a shared understanding in relation to the dietary requirements, pain management, skin integrity, mobility and hygiene care needs and preferences of consumers. Care staff were aware of strategies to effectively manage high impact or high prevalence risks associated with the care of consumers including, but not limited to, falls.

Management and staff did not have a shared understanding in relation to the legislative requirements for restricitive practices. Staff described how they would deliver care to consumers approaching the end of their life to ensure their pain management needs and comfort was managed appropriately.

Clinical incident data was recorded however, incident data in relation to the use of restrictive practices, incidents, near misses and falls was not reported to the organisation’s governing body.

Care documentation reflected consumers’ preferences in relation to end of life care and reflected the identification of, and response to, deterioration or changes in consumers’ conditions had occurred in a timely manner. Information sharing processes were effective and occurred through care plan information and handover processes.

Staff had a shared understanding in relation to the service’s escalation processes which occurred in response to the identification of clinical changes or deteriortation in the condition of consumers. After hours clinical support resources included the Facility manager/Registered nurse and Medical officers from the local hospital and community clinic. Staff, Medical officers and allied health professionals could access consumer’s care information. Management initiated all referrals to external allied health professionals who visited the service regularly including, Speech pathologists, Dieticians, Audiologists, Podiatrists, Dentists and Physiotherapists.

The organisation had policies and procedures including, but not limited to, referral processes, clinical reviews, infection control and antimicrobial stewardship however, policies in relation to restrictive practices, wound care and falls management were not available to guide staff practice. Some clinical policies including those in relation to pain management and skin integrity had not been reviewed or updated to reflect best practice information.

While some organisational policies were not current or accessible by staff, clinical care delivered to consumers was generally safe, effective and met their individual needs and preferences.

The Quality Standard is assessed as Compliant as one of the seven specific requirements have been assessed as Non-compliant.

### 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.*

### 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) Non-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.*

The service was unable to demonstrate effective infection control practices or preparedness to support the management and prevention of a potential COVID-19 outbreak.

While staff could provide examples of how they minimised infection related risks and promoted appropriate antibiotic prescribing, the service’s monitoring processes were ineffective and failed to identify the poor compliance of visitors with the service’s COVID-19 risk screening processes, personal protective equipment and influenza vaccinations.

Visitors entering the service were not monitored to ensure they had complied with the service’s COVID-19 risk screening processes. The sign in process did not effectively identify if staff, visitors or contractors who may have travelled interstate, visited a designated ‘hot spot’ or whether any circumstances prevented the person from entering the service as required in Queensland Health Residential Aged Care Directions.

Management did not have a shared understanding of Queensland Health Residential Aged Care directions including the requirements for certain persons to wear surgical masks.

Visitors to the service were not consistently requested to provide evidence of their influenza or COVID-19 vaccinations.

While the organisation had a policy regarding infection control and antimicrobial stewardship, information in relation to the role of the infection prevention and control lead had not been recorded to guide staff practice. The designated infection prevention and control lead had not completed mandatory education required by the role.

Management acknowledged the deficiencies identified by the Assessment Team during the site audit and advised the service’s sign in processes and visitors compliance with the application of personal protective equipment would be monitored.

The approved provider in its response has planned actions to address the deficiencies identified by the Assessment Team during the site audit. These include ensuring all visitors to the service provide evidence of COVID-19 and influenza vaccinations, improved accessibility of personal protective equipment for staff and visitors, improved signage visibility at the service’s entrance, mandatory education for all staff and communications in relation to the entry requirements for visitors service are planned to be communicated through the local radio station and a community notice.

I acknowledge the improvements planned by the approved provider to address the deficiencies identified by the Assessment Team however, at the time of the site audit infection control practices and preparedness to support the management and prevention of a potential COVID-19 outbreak were ineffective.

Therefore, it is my decision this Requirement is Non-compliant.

# STANDARD 4 COMPLIANT Services and support 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

Consumers said they chose the lifestyle activities they participated in and provided examples of how the service supported them to do things they wanted to do. They confirmed their emotional well being and cultural preferences were supported and respected. Consumers said they were supported to access the local community for appointments, to visit family and friends and to maintain community connections. They enjoyed the quantity and quality of meals provided by the service which accommodated their individual dietary needs and preferences.

Care planning documentation captured information regarding consumers’ needs, interests and what was important to them. Information collected from lifestyle assessments informed the service’s activity schedule which was reviewed and discussed each month at consumer and representative meetings.

Care planning documentation reflected the service supported the emotional, spiritual and psychological well-being of consumers. Care and service plans included detailed information regarding the activities and people who were important to consumers. Care planning documentation provided enough information that supported the effective and safe sharing of the consumer’s condition, needs and preferences.

Care documentation reflected the involvement of others in the provision of lifestyle supports including, but not limited to, the Lutharan pastor, indigenous community elders and the Occupational therapist. Care planning documentation included information regarding the individual dietary requirements and preferences of each consumer.

Staff had a shared understanding about what was important to individual consumers including their interests, emotional, spiritual and psychological well-being. Lifestyle staff supported conumers to participate in the National Aboriginies and Islanders Day Observance Committee week celebrations and said the local elders from the community visited consumers. Lifestyle staff supported consumers to access the local well-being centre and participate in community based activities.

Changes to consumer’s well-being , preferences and/or choices of activities was communicated between staff during shift handovers, daily meetings and in care documentation. Staff were familiar with the organisations and individuals involved in the provision of lifestyle services and supports and the dietary needs and preferences of consumers. Meals were prepared on site and meal options were rotated every four weeks and included culturally appropriate options for consumers.

Staff could access equipment to support consumer’s lifestyle needs and were aware of the service’s reactive maintenance processes. Equipment and furniture was observed to be clean and well-maintained.

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

## 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) Compliant

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

### Requirement 4(3)(c) 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.*

### 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

Consumers said the service’s living environment was clean, safe, quiet and homely. They confirmed any maintenance issues were addressed promptly and they could leave the service whenever they preferred. Consumers and representatives said the equipment was suitable for their needs, safe and well-maintained.

The service environment optimised each consumer’s sense of belonging, independence, interaction, function and included covered walkways, a central barbeque area, outdoor grassed areas and seating throughout the service.

The service’s Maintenance officer was responsible for maintain the external grounds and gardens of the service. Whilst, the Maintenance officer completed most maintenance and repairs, external trades services were accessed for more specialised repairs.

Staff had a shared understanding regarding the service’s reporting processes when potential safety hazards or equipment issues were identified. Communal areas of the service and consumer’s individual rooms were cleaned daily.

The service environment was safe, clean, well maintained and enabled consumers to move freely throughout the service. Shared equipment including mobility aids and hoists were in good condition and stored securely. Consumers and staff could access a maintenance folder observed to be in the administration area of the service.

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

## 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 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

Consumers and representatives felt encouraged and supported to provide feedback and said this could occur through speaking with management or the service’s feedback and suggestion forms. Consumers and representatives were familiar with external complaints and advocacy organisations however, they preferred to speak directly with management in relation to their concerns.

Whilst consumers and representatives said they had not needed to lodge a complaint, they expressed confidence in management’s ability to acknowledge and resolve their concerns and make improvements to the quality of care and services.

Staff had a shared understanding of the service’s complaints resolution processes and supported consumers and representatives to raise concerns and provide feedback. Staff were aware of the internal and external complaints mechanisms, advocacy and language services available to consumers to resolve complaints.

While staff had not received training in relation to the principles of open disclosure, incident documentation reflected open disclosure had been applied when incidents had occurred. Processes were in place to analyse complaints information and identify trends to inform the service’s continuous improvement activities. Actions implemented by the service in response to consumer and representative feedback were evaluated to ensure consumers were satisfied.

Consumers and representatives could raise concerns through the service’s feedback forms, monthly consumer and representative meetings, consumer experience surveys and during care and service plan reviews.

The organisation had documented policies and procedures in relation to feedback, complaints, compliments and dispute resolution processes. Complaints information was available for consumers in languages other than English, included in posters displayed throughout the service and in the service’s consumer information book. Feedback, suggestions and complaints received from consumers and representatives were recorded in the service’s complaints register and reflected in the service’s plan for continuous improvement.

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

## 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) Compliant

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

# STANDARD 7 NON-COMPLIANTHuman 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 workforce was not equipped or supported to effectively undertake their roles and to deliver outcomes required by the Aged Care Quality Standards.

The workforce had not received education or training in relation to specific legislative changes and key areas relevant to their roles and responsiblilities. Staff and management did not have a shared understanding in relation to specific key areas and management did not have capacity in their dual roles to ensure their individual training needs and managerial tasks had been completed.

While the service was unable to demonstrate the workforce was not equipped or supported to effectively undertake their roles, care and services were provided in line with the needs and preferences of consumers in a kind and caring way. Consumers provided positive feedback in relation to the provision of care and services and expressed confidence in the competency and skills of staff at the service.

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

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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.*

### 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.*

Management and staff had not received training in relation to legislative changes regarding the Aged Care Quality Standards, restrictive practices, the Serious Incident Response Scheme, the escalation and reporting of incidents and the service’s incident management system and open disclosure.

The Facility manager/Registered nurse had not received adequate support from the organisation to enable them to undertake their roles effectively and deliver the outcomes required by the Aged Care Quality Standards. The Facility manager/Registered nurse expressed concerns in relation to their limited capacity to undertake both roles concurrently at the service. Further to this, they confirmed education and training in relation to their responsibilities for both positions had not been provided by the organisation. For example, restrictive practices, the Serious Incident Response Scheme, the use of an Incident Management System or the Infection Prevention and Control Lead mandatory course.

The service’s training calendar did not reflect planned education in relation to the Aged Care Quality Standards, restrictive practices, incident management and the Serious Incident Response Scheme had been scheduled. Policies and procedures were not accessible by staff and had not been updated to reflect legislative changes or open disclosure.

The approved provider in its response states it has planned actions to address deficiencies identified by the Assessment Team during the site audit. These include initial and ongoing mandatory staff/management education in relation to the Serious Incident Response Scheme and restrictive practices.

I acknowledge the approved provider’s response however, I am not satisfied actions planned will address all deficiencies identified by the Assessment Team for this Requirement. The approved provider has not included information in their response to demonstrate how planned improvements will be monitored or evaluated for effectiveness.

Therefore, it is my decision this Requirement is Non-Compliant.

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

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

# STANDARD 8 NON-COMPLIANTOrganisational 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

Consumers and representatives considered the organisation was generally run well and they could partner in the improvement of care and services. They expressed satisfaction with how the service had engaged with them in the development, delivery and evaluation of care and services.

The organisation was unable to demonstrate the organisation’s governing body promoted, was accountable for or had monitored the delivery of safe and quality care and services.

The organisation did not have effective governance systems in relation to information management, continuous improvement, workforce governance and regulatory compliance.

The organisation was unable to demonstrate it had effective risk management systems and processes, including the management of high impact and high prevalence risks associated with the care of consumers specifically in relation to the management and prevention of incidents, including through the use of an effective Incident Management System.

The organisation did not have effective clinical governance systems and processes in place to support the delivery of safe and quality clinical care and results in satisfactory clinical outcomes for each consumer.

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

## 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) Non-compliant

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

The organisation’s governing body had not promoted, demonstrated accountability for and/or monitored the delivery of safe and quality care and services.

While organisational policies identified a leadership structure which outlined the roles and responsibilities of various positions at the service and organisational level, the Director and/or Council had not received and did not seek key information in relation to risks associated with the care of consumers to promote and ensure the delivery of safe, inclusive and quality care and services. This included information pertaining to the use of restrictive practices at the service, incidents or near misses which may require reporting in accordance with the Serious Incident Reporting Scheme and falls data.

Management was unable to identify any changes including improvement actions driven by the Council within the previous 12 months in response to consumer and representative feedback and incidents. Management and the Chief Executive Officer confirmed the Council was disengaged with the service. During the site audit, management revised the monthly report for the Director to include information relating to the Serious Incident Response Scheme, restrictive practices and high impact/high prevalence risks associated with the care of consumers at the service including falls.

The Chief Executive Officer and Council did not have a shared understanding of legislative changes regarding restrictive practices, the Serious Incident Response Scheme and the Council’s responsibilities in relation to this Requirement.

The approved provider in its response has planned actions to address the deficiencies identified by the Assessment Team during the site audit. These include a review of the organisation’s delegations of responsibility, the development of new policies and procedures to reflect information regarding the organisation’s delegation pathways and responsibilities, possible reallocation of high level decision making. Further to this, the monthly report will be revised to include reportable incidents, clinical incident data and trends, restrictive practices, psychotropic medication usage, antimicrobial stewardshiop wounds and consumers receiving palliative care. The monthly report will include information in relation to continuous improvement and self-assessment activities, staff training, human resources, feedback, consumers engagement and good news stories. The approved provider will ensure information regarding their legislative responsibilities is sought and contributes to the organisation’s continuous improvement.

I acknowledge the actions planned by the approved provider however, at the time of the site audit, the organisation’s governing body did not promote *a* culture of safe, inclusive and quality care and services and is accountable for their delivery*.*

Therefore, it is my decision this Requirement is Non-compliant.

### 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.*

The service did not have effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance and regulatory compliance.

While consumers and representatives said they were provided with enough information regarding their care and services and staff could generally access the information they required to deliver safe and quality care and services, organisational policies and procedures were not current, easily accessible or in a format they understood.

Current and out of date policies were stored collectively on the service’s electronic care management system and were not consistently reviewed and updated to reflect legislative changes in relation to incident reporting, legislative timeframes, processes the use of an incident management system or policies and procedures in relation to falls. The service did not have an organisational policy in relation to restrictive practices and forms or templates including authorisations or behaviour support plans had not been developed to assist the service in the assessment, monitoring and management of restrictive practices.

The staff information handbook had not been updated to reflect legislative changes associated with incident reporting in accordance with the Serious Incident Response Scheme.

The approved provider in its response has planned actions to address the deficiencies identified by the Assessment Team in relation to the organisation’s management of information. These include the purchasing and contextualising of policies, procedures and restrictive practice authorisation forms from an external aged care peak body advisory group and the revision of the service’s staff information handbook.

The service’s plan for continuous improvement processes were not reflective of all improvements initiated and/or completed at the service. Management did not have the time to regularly update this document. Monitoring processes were not effective in circumstances where the service has failed to identify and/or implement actions to rectify the deficiencies identified by the Assessment Team in relation to assessment and care planning, minimising infections related risks, staff knowledge and training and the accuracy and availability of policies and procedures.

The approved provider in its response has planned actions to address the deficiencies identified by the Assessment Team in relation to the organisation’s continuous improvement processes. These include internal audit review processes and surveying Councillors to ascertain their understanding of their roles in continuous improvement processes.

The workforce was not trained, equipped or supported at a service and organisational level to effectively perform their roles and to deliver the outcomes required by the Quality Standards. Staff and management had not received training relevant to their roles and did not have a shared understanding of the Serious Incident Response Scheme and restrictive practices.

Monitoring processes were not effective and failed to identify changes in legislation through correspondence from national peak bodies, external agencies and regulatory bodies. Organisational policies and procedures did not reflect legislative changes, management and staff were not aware of legislative changes in relation to the Serious Incident Response Scheme and restrictive practices.

Staff had not been provided education and training regarding these topics. Management did not have a shared understanding regarding the requirement for specialist infection prevention and control lead training. The Chief Executive Officer did not monitor changes in relation to legislative requirements and was not aware of the implementation of the Serious Incident Response Scheme or changes made to restrictive practices. While no incidents had been recorded which met the reporting criteria for the Serious Incident Response Scheme, the service did not consider and/or document in the service’s incident management system, whether the consumers who was subject to a restrictive practice without an appropriate assessment, authorisation or informed consent in place constituted a reportable incident under the Serious Incident Response Scheme.

The approved provider in its response has planned actions to address the deficiencies identified by the Assessment Team in relation to regulatory compliance. These include ensuring legislative changes are reflected in the organisation’s policies and procedures, communicating changes to legislation to staff and providing education for both staff and management in relation to the Serious Incident Response Scheme and the service’s Incident Management System.

I acknowledge the improvements planned by the approved provider to address the deficiencies identified by the Assessment Team in relation to regulatory compliance however, at the time of the site audit the organisation’s governance wide systems were ineffective in relation to information management, continuous improvement and regulatory compliance.

Therefore, it is my decision this Requirement is Non-compliant.

### 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.*

While the organisation had a risk management framework which addressed risks to consumers including high impact high prevalence risks, some policies including those in relation to pain management, skin integrity, the abuse and neglect of consumers and incident management and prevention had not been reviewed since 2019 or updated to reflect legislative changes. The organisation had not developed a falls management policy despite this being identified as the greatest risk associated with the care of consumers at the service.

Staff were unable to access the beforementioned policies however, had a shared understanding of various risk minimisation strategies in relation to falls, pressure injuries and infections, elder abuse and neglect and dignity of risk.

While management did not have a shared understanding of the Serious Incident Response Scheme, staff had a sound understanding regarding the identification and escalation of incidents.

The service’s electronic care management system did not enable the service to effectively trend and analyse incidents to identify risks to consumers, inform continuous improvement actions, nor the effectiveness of remedial actions taken. While no documented incidents have occurred at the service which would constitute a reportable incident for the Serious Incident Response Scheme, the service had not considered and/or documented in their Incident Management System whether the named consumer subjected to a restrictive practice without an appropriate assessment, authorisation or informed consent in place constituted a reportable incident under the Serious Incident Response Scheme.

The approved provider has planned improvement actions to address the deficiencies identified by the Assessment Team during the site audit. These include the purchasing of policies from an external peak body advisory group, the manual collation, trending and reporting of clinical incident data each month included in the service’s monthly report.

I acknowledge the improvements planned by the approved provider to address the deficiencies identified by the Assessment Team in relation to the organisation’s risk management systems and practices however, at the time of the sites audit, the organisation’s risk management systems and practices were not effective.

Therefore, it is my decision this Requirement is Non-compliant.

### Requirement 8(3)(e) Non-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.*

The organisation did not have effective clinical governance systems and processes in place that supported the delivery of safe and quality clinical care or resulted in satisfactory clinical outcomes for each consumer.

The organisation had not developed a documented clinical governance framework or policies, procedures and other relevant documentation and templates in relation to the minimising the use of restrictive practices. For example, behaviour support plans and restrictive practice authorisation forms.

While the organisation had policies and procedures in relation to open disclosure and antimicrobial stewardship, these policies had not been discussed with staff. Policy information did not reflect the responsibilities of the service’s infection prevention and control lead. Management understood the principles of antimicrobial stewardship and care staff had a shared understanding regarding strategies to minimise the risk of infections.

However, management and staff did not have a shared understanding regarding the principles of open disclosure or when open disclosure should be applied in accordance with the organisation’s policy. While management and staff did not have a shared understanding, management provided relevant examples of when an open disclosure process had been applied.

Management had a limited understanding of the legislative requirements regarding the use of restrictive practices and the development and completion of behaviour support plans. Further to this, the Facility Manager/Registered nurse was unable to provide consistent clinical governance which resulted in deficiencies in relation to assessment, care planning and the minimisation of infection related risks.

Care staff did not have a shared understanding in relation to restrictive practices, nor their responsibilities required as part of their role. For example, monitoring processes for the use of restrictive practices.

The service had not assessed, nor obtained informed consent from a named consumer or their representative prior to the use of restrictive practice.

The approved provider in its response has planned improvement actions to address the deficiencies identified by the Assessment Team during the site audit. These include the development of a Clinical Governance Framework, undertake Clinical Governance self-assessments to identify areas for improvement, staff education in relation to antimicrobial stewardship, open disclosure and mimising the use of restrictive practices.

I acknowledge the improvements planned by the approved provider in relation to the organisation’s clinical governance framework however, at the time of the site audit the organisation did not have a clincal governance framework including, but not limited to antimicrobial stewardship, minimising the use of restraint and open disclosure.

Therefore, it is my decision this Requirement is Non-compliant.

# 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.

* 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.
* Minimisation of infection related risks through implementing: standard and transmission based precautions to prevent and control infection.
* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Effective organisation wide governance systems relating to information management, continuous improvement and regulatory compliance.
* Effective risk management systems and practices, including but not limited to managing high impact or high prevalence risks associated with the care of consumers.
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.*
* 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.*