Performance

Report

**1800 951 822**

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| Name: | Arcare Belmont |
| Commission ID: | 8234 |
| Address: | 2B Maude Street, BELMONT, New South Wales, 2280 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 9 July 2024 |
| Performance report date: | 22 July 2024 |
| Service included in this assessment: | Provider: 1706 Arcare Pty Ltd  Service: 28176 Arcare Belmont |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Arcare Belmont (**the service**) has been prepared by G Cherry, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* the provider acknowledged receipt of the assessment team’s report on 12 July 2024.
* Performance Report dated 9 January 2024.

# Assessment summary

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| Standard 8 Organisational governance | Not appliable as not all requirements assessed |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management. 2. continuous improvement. 3. financial governance. 4. workforce governance, including the assignment of clear responsibilities and accountabilities. 5. regulatory compliance. 6. feedback and complaints. | Compliant |

Findings

A decision of non-compliance made on 9 January 2024 followed a site audit assessment during November 2023. At an assessment contact on 9 July 2024 the provider supplied a current/ongoing plan for continuous improvement (PCI), detailing improvement strategies and actions to address previously identified non-compliance.

The assessment team bought forward evidence actions taken in response to the non-compliance have been effective as the organisation demonstrates effective governance exists to monitor/manage information management, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints. Interviewed consumers advise they feel safe and cared for, expressing satisfaction staff are kind, caring and knowledgeable. Information management systems include an electronic care planning, a quality incident/risk management, and feedback/complaints systems. The incident management system installed in November 2023 resulted in improved reporting capabilities for both service and executive management teams. A range of meetings, reports and other information are reported from service level to the executive team which is addressed/analysed at appropriate working groups/committees and escalated to the executive leadership team and Board as required. At an organisational level development of robust data input/analysis systems provides the governing body appropriate information.

The chief executive officer (CEO) communicates with consumers/representatives via newsletter regarding significant changes in process. Policies/procedures are monitored/reviewed by relevant working groups and changes are disseminated to managers and staff. Review occurs to measure service compliance regarding changes. Consumers express satisfaction with receipt of information and methods used, noting provision of information enables choice. At both organisation and service level systems ensure ongoing monitoring of consumer outcomes and service performance against the Quality Standards to inform improvement. Review of documentation detail numerous examples of improved outcomes. Quality team members complete regular monitoring, conduct trending/analysis, and escalate to the Board as required. At an organisational level, the Board implemented clinical staff training regarding cardiopulmonary resuscitation and purchased automatic defibrillators for each service. Financial delegations ensure expenditure within budget, plus a process exists for out of budget items when required. Interviewed staff note prompt response to requests for additional equipment.

A baseline workforce framework directs staffing numbers to ensure sufficiently skilled/qualified staff to provide safe, respectful, quality care/services. Organisational expectations of roles and responsibilities is assigned to each staffing department. Organisational teams focus on recruitment/onboarding, oversee performance management/learning plus responsibility for education/training. An electronic rostering management system supports rostering, and a business analyst ensures compliance with legislative care minute requirements. Management aim to maintain a dedicated staffing model in consultation with team members to ensure continuity of consumer care. Consumers express positive feedback relating to staff skill/sufficiency. An organisational legal counsel informs of legislative changes which are reviewed/discussed at relevant meetings, policies reviewed/changed/ratified at Board level and implementation at service level. An example of change was provided in relation to environmental restrictive practice. The organisation now uses the Commission’s perimeter restraint self-assessment tool in response to previously identified non-compliance. Interviewed staff demonstrate knowledge/awareness of changes noting completion of training relating to this. Complaints and feedback are collected via the incident management system, monitored by Management at service level and the quality team at organisational level. Complaints are discussed, analysed, and trended at clinical risk meetings and referred to the Board via clinical governance meetings. Sampled consumers consider the service is responsive to feedback and complaints.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)