Performance

Report

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| Name of service: | Performance report date: |
| Arcare St James | 12 July 2022 |
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| Arcare Pty Ltd | 7 June 2022 – 9 June 2022 |

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

**This performance report**

This performance report for Arcare St James (**the service**) has been considered by Denise McDonald, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the assessment team’s report for the site audit, the assessment report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received on 1 July 2022.

# Assessment summary

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

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 2(3)(b) – The provider ensures 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 7(3)(e) – The provider ensures regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

# Standard 1

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

## Findings

Consumers felt they were treated with dignity and respect and they were supported to maintain their culture and identity. Care planning documents reflected consumers’ background, identity, religion and cultural practices. Staff described how the admission process captures information about the consumer’s background, culture and specific preferences for their care and services. Staff were familiar with individual consumer’s backgrounds, and how they could support their needs and preferences. The service celebrated different social and cultural events and demonstrated consumers’ culture and identity was valued and catered to.

Consumers/representatives felt supported to make decisions about their care, involve others they wanted to, and maintain important relationships. Staff described how they supported consumers to be independent, take risks and make choices about their care and services and live the best life they could. Where chosen activities involved risks, the service assessed and mitigated the risks in consultation with consumers/representatives. Consumers/representatives said they were provided with current, accurate and easy to understand information to assist them make informed choices about their daily care and services. The service provided printed lifestyle information, menus and supported other forms of communication, as appropriate for the consumer.

The service demonstrated privacy was respected and personal information was kept confidential. The Charter of Aged Care Rights poster was displayed throughout the service and published in the staff handbook. Staff were observed respecting consumers’ privacy by knocking on doors before entering and closing doors when care was provided. Consumers/representatives said staff were respectful of privacy. Staff completed training on privacy and confidentiality, and information was stored on a password protected electronic system.

# Standard 2

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

## Findings

The assessment team’s report recommended that Requirement 2(3)(b) was Not Met. After consideration of the evidence, including issues identified under Standard 3 in the Assessment Report, I have found that Requirement 2(3)(b) is Non-compliant. Evidence of deficits identified in the assessment team’s report included:

* The assessment team identified 11 consumers without advance care directives and 2 consumers with challenging behaviours that did not have personalised behaviour support plans.
* One consumer did not have a behaviour support plan (BSP) despite exhibiting challenging behaviours. While the challenging incidents were documented, and staff were aware of strategies to manage the behaviours, no BSP had been prepared and included in their care plan.
* One consumer with dementia related challenging behaviours had a BSP however, it was considered generic and was not sufficiently personalised with inadequate instructions about known de-escalation strategies for their challenging behaviours.
* One consumer receiving oxygen therapy was not having their oxygen saturation levels checked and recorded daily in accordance with their complex care plan. The service indicated the medical officer had advised the oxygen levels were to be recorded weekly rather than daily however, they were not being consistently recorded either weekly or daily.
* During the admission process the advance care preferences and end of life wishes are discussed, if the consumer/representative is ready to have this conversation. Staff will revisit the conversation, during case conferences or care plan reviews and it may take time to complete with all relevant people.

The provider’s response acknowledged the observations made in the assessment team’s report but did not agree with the finding of Not Met. The provider furnished additional evidence and information about actions taken by the service in relation to gaps identified by the assessment team. The provider advised:

* Both consumers identified as having challenging behaviours were being closely monitored and receiving effective care, oversighted by their relevant medical officers.
* At the time of the audit, a behaviour support plan was being formulated for one consumer who had only recently returned to the service after an extended hospital admission for a psychiatric evaluation and medication review, following an incident.
* At the time of the audit, the service had identified a gap in behaviour support plans and put a continuous improvement plan in place dated 28 March 2022. The corrective actions included review and further personalise all care plans particularly behaviour support plans.
* The service has since reviewed and updated all behavioural support plans to ensure they contain current and individualised information in line with the comments made during the site audit. The service is conducting education with all clinical team members to improve their knowledge and skills in this area.
* The service has reviewed the oxygen charting directions for one consumer and acknowledged they could be potentially confusing for team members. The consumer’s oxygen therapy has been reviewed by the medical officer and a new oxygen chart commenced to give clearer guidance and remove any confusion.
* An independent survey conducted in the previous 6 months, found 100% of clients and 93% of representatives confirmed they were satisfied with their involvement in the care planning process.

While some consumers did not have advance care directives in place, I have no evidence this is due lack of opportunity rather than a matter of personal choice. I note many consumers did have advance care plans in place and the service cannot compel consumers, or their families, to discuss advance care or end of life planning, if they do not wish to. While there may be scope for the service to improve their approach to advance care and end of life planning, I am satisfied the assessment and planning process included advance care and end of life planning.

While I consider it reasonable for a service to take some time to identify and assess emergent challenging behaviours, there is evidence the service had not adequately documented behaviour support plans for 2 consumers with known challenging behaviours. I acknowledge the service has moved promptly to review and put in place current behaviour support plans for all relevant consumers however, at the time of the audit, I am not satisfied the service’s assessment and planning identified and addressed these aspect of consumer’s current needs, goals and preferences.

I find the remaining 4 Requirements of Quality Standard 2 are Compliant as:

The service demonstrated assessment and care planning, including risks to the consumer's health and well-being, informed the delivery of safe and effective care and services. The needs, goals and preferences of the consumer were identified when the consumer entered the service and initial assessments were completed within the first 24 hours. Further assessments were completed during the first 28 days at the service. All consumers interviewed had advance care directives in place, which had been discussed with families.

The service’s policies identified consumers/representatives and other health professionals as partners in the care planning process. Consumers/representatives confirmed their care needs were documented and they could access their care plan, if they wished. Communication between staff and other health providers was effective and changes in consumers’ condition were identified and responded to appropriately. A physiotherapist and occupational therapist visited the service multiple times a week and other allied health services were accessed through timely referrals. Input from other health professionals was incorporated into the consumers’ care plan and reflected in their daily care. The service reviewed care plans on a regular 6-monthly basis, or as circumstances changed or incidents impacted on the needs, goals or preferences of the consumer.

# Standard 3

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

## Findings

The assessment team’s report recommended Requirements 3(3)(a) and 3(3)(b) as Not Met however, after consideration of the evidence, I find the service has delivered effective personal and clinical care to consumers. Evidence in the assessment report which relates to the assessment and planning of care needs has been considered under Standard 2(3)(b). Evidence of deficits identified in the assessment team’s report included:

* Three consumers said they had experienced incidents where stocks of their sized incontinence pads had run out. The service said they were not aware of any problems with the supply of incontinence pads and said they would investigate this claim with staff further.
* Two consumers did not have an adequate behaviour support plans (BSP) despite exhibiting challenging behaviours. (see Requirement 2(3)(b))
* One consumer receiving oxygen therapy was not having their oxygen saturation levels checked and recorded daily in accordance with their complex care plan. The service indicated the medical officer had advised the oxygen levels were to be recorded weekly rather than daily. (see Requirement 2(3)(b))
* One representative had requested antidepressant medication for a consumer be recommenced as they felt their ‘mood had dropped significantly’. The medical officer had ceased the prescription however, there was no behaviour charting for this period. Management advised they regularly catch up with the consumer and had not noticed any changes in mood.
* One representative said the service provides inconsistent care for a consumer and ‘they do not seem to be able to deal with a dementia patient’. The service does not have a memory support unit.
* One representative was concerned staff were not ‘believing’ the consumer when they had issues, due to their history of challenging behaviours.
* The Assessment Team identified a consumer who was potentially subject to chemical restrictive practice, had not been identified by the service.

The provider’s response acknowledged the observations made in the assessment team’s report but did not agree with the finding of Not Met. The provider furnished additional evidence and information about actions taken by the service in relation to gaps identified by the assessment team’s report. The provider advised:

* The service was unaware of any issues with availability of continence pads and there was no record of complaints about running out of pads from the relevant consumers despite having had recent care conferences. The consumers toileting and continence assessments in their care plans were current and had been recently reviewed.
* The medical officer treating one consumer was reducing the dose of some medication in close consultation with the consumer and best clinical practice.
* The consumer identified as potentially chemically restrained was prescribed the psychotropic medication by a doctor for an appropriate diagnosed condition. The medication was not prescribed as a restraint and the consumer’s medical care was current and closely supervised by the relevant medical officers.

Overall, consumers considered they received personal and clinical care that was safe and right for them. ‎Consumers/representatives said care was individually tailored with timely referral and access to doctors or other health professionals, when needed. ‎Representatives confirmed consumers received care which met their needs and preferences, including for advance and end of life (EOL) care, where their dignity and comfort is assured. Consumers/representatives confirmed information about the consumer’s current condition, needs and preferences was documented and effectively communicated to those involved in the delivery of care. ‎‎Consumers/representatives said the service had good infection control and antibiotic prescribing practices and managed COVID-19 well.

The service had systems and processes to ensure consumers receive safe and effective personal and clinical care. The service had best practice policies, procedures, guidelines and flowcharts for key areas of care including; restrictive practices, skin integrity and pain management. Clinical audits, key indicators and staff training supported best practice clinical care. Staff had access to this information. The service recorded, analysed and responded to clinical indicators, incidents and identified risks. Clinical indicators were discussed at staff meetings and were used to identify improvements in the delivery of consumer care. Management noted staff attendance at these meetings had been declining and they had recently made attendance compulsory.

The service had policies and procedures to minimise infection risks including an infection control plan. Staff were observed maintaining safe distance and using personal protective equipment, where appropriate. One staff member was observed not using good sanitary practice during a medication round and the service responded by conducting a hand hygiene and medication competency. The service maintained a record of staff and consumer vaccinations. Staff understood the term ‘antimicrobial stewardship’ and provided examples of how antimicrobial usage was minimised at the service such as; encouraging fluid intake, practicing good hygiene and ensuring pathology results support treatment with antibiotics.

Staff demonstrated an understanding of precautions to prevent and control infection and could mostly identify the highest prevalence risks for different cohorts of consumers and how incidents were used to inform changes in practice. The assessment team’s report evidenced the service demonstrated how high impact high prevalence risk such as; falls, nutrition and hydration were managed and mitigated, however they did not find challenging behaviours had appropriately documented behaviour support plans.

I have considered deficits identified in the assessment team’s report in relation to care planning documentation under Requirement 2(3)(b). I do not consider there is evidence the deficits in documentation adversely impacted care delivery. I am satisfied with the provider’s additional explanatory information, and I consider the service has demonstrated the care and services provided were safe and effective for each consumer.

# Standard 4

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

## Findings

Consumers/representatives felt they received the services and supports for daily living that were important for their health and well-being and enabled them to do the things they wanted to. ‎Consumers/representatives felt supported by the service to do things of interest to them, which included participating in activities within the service and outside in the community. Consumers said they could access external organisations, support services and other service providers. Consumers said their emotional, spiritual and psychological needs were supported and they could stay in touch with family or friends for comfort and emotional support. They said they can meet freely at the service or use technology to stay in touch with them.

Consumers/representatives expressed satisfaction with the variety, quality and quantity of food provided at the service. Consumers and staff reported equipment used to support activities for daily living was safe, suitable, clean and well-maintained.

The service demonstrated consumers received safe and effective services and supports for daily living that met their needs, goals and preferences. Staff showed an understanding of specific consumer’s daily living needs and preferences, and how they helped them do the things they want to do. Care planning documentation set out the information about consumers' daily living needs and preferences and this was communicated effectively within the service and to others involved in providing care and services. Staff could describe how they document and share information and were kept informed of the changing condition, needs and preferences of each consumer.

Dietary needs and preferences were documented appropriately, and this information was readily available to the catering staff. Meals were observed to be an appropriate size, matched the menu description and were mostly eaten by consumers. The menu is rotated 6-weekly for variety and changed seasonally. The menu has several options for breakfast, lunch and dinner with alternatives. The kitchen and serveries were clean and tidy with staff observing general food and workplace safety protocols.

The equipment provided at the service was safe, suitable, clean and well maintained. ‎Mobility aids, such as walkers and wheelchairs, were clean and appeared to be functioning appropriately. ‎‎A range of lifestyle activity products, such as puzzles, games and a large variety of nail polish were available and appeared to be in good condition. ‎‎‎Equipment used to provide laundry, cleaning and catering was clean and in working order.‎ Care staff described how they cleaned equipment with shared equipment being cleaned after every use.

Preventative and reactive maintenance logs demonstrated maintenance issues are rectified by maintenance staff in a timely manner. **Standard 5**

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

## Findings

Consumers felt at home, were safe and comfortable in the service. They could move freely in the service and access outdoor areas, as they wished. Consumers reported the service and the equipment, furniture and fittings were clean, safe, well maintained. Consumers’ rooms showed a high degree of personalisation with photographs, decorations, furniture and items of importance on display in their room. Room doors had a personalised sign with the consumer’s name and room number.

The service environment was easy to navigate, with the layout of the buildings going around a communal cafe in the centre. The service appeared welcoming, with dementia friendly design principles, natural light, clear signage and handrails to support consumers to move around. There were several shared areas for consumers to socialise, indoors and outdoors. The outdoor areas had walkways and garden areas, with tables and chairs for consumers. The dining areas appeared homely and consumer interactions were observed during mealtimes. Furniture in communal areas was observed to be clean and in fair condition.

The service does not have memory support unit and all consumers were free to enter and exit the service at their own accord, notwithstanding there were some after-hours security measures. Consumers and their visitors were observed freely accessing all areas of the service, including the outdoor courtyard area and central café.

External pathways were observed to be clear of trip hazards and well maintained. Staff were seen cleaning common areas and consumers' rooms throughout the site audit, and cleaning high touch points regularly. Kitchenettes, laundry, equipment and cleaning storage trolleys were clean and well maintained with materials appropriately stored.

The flooring, walls, ceilings, and outdoor areas, of the service were clean and well-maintained. At the time of the site audit, one of the dining rooms was closed off while external contractors were conducting major repairs to the roof caused by the rain, with 2 of the 3 wings receiving tray service for meals for the week.

‎‎Consumers could access a range of equipment such as; walking frames, wheelchairs, and comfort chairs. These were observed to be clean and in good condition. The service’s preventative maintenance schedule evidenced regular maintenance was occurring, and the service’s reactive maintenance log showed issues reported by staff were resolved promptly.

**Standard 6**

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| Feedback and complaints | | Compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

## Findings

Overall, consumers felt encouraged and supported to give feedback and make complaints, and appropriate action was taken. ‎Consumers/representatives understood how to give feedback or make a complaint and said they felt comfortable doing so. Most consumers were aware of external complaint avenues and the advocacy supports available to them, if they needed.

Consumers/representatives described ways they could raise concerns such as; speaking directly to staff or management, completing a feedback form, or through consumer meetings. They said management addressed and resolved concerns and complaints raised, or when an incident had occurred. Consumers/representatives gave examples of the service using open disclosure in responding to complaints and using feedback to improve the quality of their care and services.

The service demonstrated consumers were made aware of internal and external mechanisms to raise and resolve complaints. Staff could explain the advocacy and language services available to consumers and how they would support consumers from diverse backgrounds, or those having difficulty communicating. Staff could describe how they responded to consumer/ representative feedback in line with the service’s open disclosure and complaints policies. Management described how they ensured consumers felt supported to provide feedback and complaints, and staff practice an open disclosure process. ‎Care staff said if a consumer raised an issue or concern, they asked them to explain the issue and if they could not resolve it, they would escalate it to clinical staff.

‎‎Management explained the different ways consumers were encouraged and supported to make a complaint and provide feedback. The service's feedback form was accessible to all consumers in reception along with a locked lodgement box. Consumers were invited to access the complaints process at every consumer meeting and staff were encouraged to resolve issues within their remit and assist consumers to complete feedback forms.‎ ‎‎

The feedback and complaints register showed the service captured compliments, complaints, and suggestions. All complaints appeared to have been actioned in accordance with the service's feedback and complaints procedure.

The service showed feedback and complaints were used to improve the quality of care. The feedback and complaints register showed all documented complaints were investigated and recommended actions entered on the continuous improvement plan. Items on the continuous improvement plan had been aligned to the Quality Standards.**Standard 7**

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

## Findings

The assessment team’s report recommended Requirement 7(3)(e) was Not Met. After consideration of the evidence, I have found Requirement 7(3)(e) is Non-compliant as the service could not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce. Evidence of deficits identified in the assessment team’s report included:

* The service’s policy indicated line managers would conduct performance reviews at least annually, at the request of a team member or as required.
* Management said they were aware some performance appraisals were overdue as challenges across the aged care sector generally had led to conflicting priorities and staff performance was being monitored through daily supervision, feedback, competency training and checking.
* The service was unable to advise how many performance appraisals were overdue because the status tracker had not been kept up to date.
* Most staff interviewed recalled their most recent annual performance appraisal was in the last year. Two care staff could not recall a recent performance appraisal.
* Management provided details of a continuous improvement plan item from 4 March 2022, which showed the issue had been identified and an action plan was being implemented. Management advised the plan was to have the reviews completed by 30 June 2022.

The provider’s response acknowledged the observations made in the assessment report and provided additional information in relation to this finding. The provider also submitted information and evidence of actions taken by the service to address gaps identified in the assessment team’s report. The provider advised:

* The service acknowledged the regular performance appraisal process had not been managed or recorded effectively. An excel spreadsheet which required manual updating had not been updated due to workforce challenges associated with 2 recent COVID-19 outbreaks.
* At the time of the audit the Assessment Team was made aware the service had identified the issue and a continuous improvement plan action was commenced in March 2022 setting out corrective actions for completion by 30 June 2022.
* To date, the service has completed 95% of annual performance appraisals with some team members not being finalised due to leave.
* To address this issue long term, team member performance appraisal records will be maintained in the electronic platform in use for Arcare’s human resource functions.

‎I acknowledge the service faced additional challenges arising from COVID-19 and the governance systems had identified deficits in relation to staff performance reviews. However, at the time of the audit, the service could not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce was occurring.

I find the remaining 4 Requirements of Quality Standard 7 are Compliant as:

The service demonstrated the workforce was 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. Where consumers/representatives had expressed concerns about staffing numbers, the service showed effective management strategies addressed the concerns. Staff did not appear to be rushing and care seemed gentle. Management had workforce planning and rostering arrangements which took account of planned and unplanned absences. The average call bell response for the period 22 - 30 May 2022 was 3 minutes 5 seconds, with 10.61% of responses being over the service’s benchmark of 8 minutes.

Most consumers considered they got quality care and services when they needed, from people who were knowledgeable, capable and caring. Consumers/representatives said staff were kind, caring and gentle and there were enough staff, overall. They considered staff to be skilled enough to perform their duties effectively and could not identify any areas where they needed further training.

Members of the workforce had the qualifications and knowledge to effectively perform their roles. Management described how position descriptions included key competencies, qualifications and police checks. New staff received mandatory training and supervised orientation. All staff received ‎ongoing and annual mandatory training, and this was monitored centrally by the organisation.

If staff made a mistake or something went wrong, the investigation process included management meeting with the staff member, to determine what could be done to prevent it happening again including the staff member would be required to re-do any relevant competencies or training modules.

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**Standard 8**

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| Organisational governance | | Compliant |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

## Findings

Consumers/representatives considered the organisation was well run and they could partner in improving the delivery of care and services. Consumers/representatives described various opportunities to be involved in the development of services and activities through consumer meetings, feedback mechanisms and regular surveys. ‎‎Consumers/representatives said the service communicates with them regularly and in a timely manner to keep them informed and active in the evaluation of the care and services provided. The service has established processes to support consumers to engage in the development, delivery and evaluation of care and services.

Management said the governing body was accountable and promoted a culture of safe, inclusive, and quality care through its policies and procedures. The Board has strategic oversight of 2 operational committees who manage the clinical and non-clinical aspects of service delivery. Each committee has sub working groups that address; dementia care, clinical quality and safety, restrictive practices, financial management, maintenance and human resources. The Board has an early warning system within the governance structure to identify potential non-compliance within the organisation, so measures can be taken before incidents occur.

The service demonstrated how it has implemented effective governance systems relating to; management of information, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints. The service has documented policies and procedures that guide clinical practices and risk management, and staff demonstrated their understanding of these policies and provided examples of how they are implemented in practice.

The service has effective risk management systems to prevent and respond to any high-prevalence risks, abuse or neglect of consumers, preventing incidents and ultimately supporting consumers to live the best life they can. Staff are guided by a risk management framework which outlines roles and responsibilities in the event of critical incidents and how to identify consumer risk. ‎Staff demonstrated an understanding of consumers with high impact or high prevalence risks and demonstrated how they implement the service's policies in alignment with best practice.

The service has a clinical governance committee and clinical governance framework that covers antimicrobial stewardship, minimising the use of restraint and open disclosure. Staff had been educated about the policies and could provide examples related to their roles. Management advised they don’t use any forms of physical restrictive practice and psychotropic medications are only administered with informed consent from the consumer/representative, after alternative strategies have been tried, where there is a clinical diagnoses and prescription from a doctor. Anti-microbial stewardship guides visiting doctors to reduce antibiotic prescription where possible. Infections and antibiotic prescriptions are monitored monthly through the multi-disciplinary meetings.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)