Performance

Report

**1800 951 822**

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| Name: | Ashleigh House Hostel |
| Commission ID: | 3026 |
| Address: | 20-24 Bergen Crescent, SALE, Victoria, 3850 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 August 2024 to 8 August 2024 |
| Performance report date: | 29 August 2024 |
| Service included in this assessment: | Provider: 680 Ashleigh House Ltd  Service: 1785 Ashleigh House Hostel |

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 Ashleigh House Hostel (**the service**) has been prepared by N Eastwood, 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’s response to the assessment team’s report received 28 August 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not 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.

Standard 3

* Requirement 3(3)(b) implement adequate systems to support consistency in identification and management of high-impact or high-prevalence risks.
* Requirement 3(3)(d) ensure timely action and escalation of care to medical practitioners occur where deterioration or change to consumer physical and cognitive condition is identified.

Standard 8

* Requirement 8(3)(d) implement and sustain processes to identify and manage risk.
* Requirement 8(3)(e) ensure adequate clinical oversight and accurate reporting of clinical data to the Governing Body, particularly where consumers are subject to psychotropic medications or restrictive practices.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 3(3)(b) and 3(3)(d), and as a result does not comply with Standard 3.

Requirement 3(3)(b)

Most consumers and representatives provided positive feedback about the care they receive, but the service did not demonstrate consistency in identifying and managing high-impact or high-prevalence risks. The Assessment Team report reflected evidence of inconsistent clinical assessment, monitoring, data recording, and interventions documented for consumers following a fall, or as a result of swallowing difficulties and consumers subject to chemical restraint were not identified.

The Assessment Team report identified specific examples of consumer impact related to service acquired pressure injuries, inconsistent recording of observations following a fall and failure to adequately escalate consumer conditions to treating practitioners. Chemical and environmental restraints were not recorded or correctly identified according to legislative requirements. Restraint authorisation forms were not supported by evidence of consultation, with the consumers or representatives, to ensure consent to the restrictive practices and behaviour support plans did not reflect individualised interventions.

Requirement 3(3)(d)

Care documentation reflected inconsistency in taking timely action and/or requesting medical assessment in response to deterioration or changes in a consumer’s physical and cognitive function. The Assessment Team report reflected examples of consumer impact where treating practitioner review was delayed or had not occurred, inadequate assessment and management of changed behaviours and a lack of consistent clinical oversight.

The Approved Provider submitted a response (the response) accepting the Assessment Team findings. The response included a plan to address the identified deficits, timeframes and responsible parties. I acknowledge that the Approved Provider had self-identified areas for improvement within the service and encourage them to progress the planned actions to ensure best practice care delivery. I find Requirements 3(3)(b) and 3(3)(d) non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Consumers and representatives were satisfied with staff skills and knowledge. Management described recruiting and onboarding processes to ensure staff comply with the service’s requirements and that staff are supported to meet their roles. Staff are required to complete annual mandatory training and have access to additional training. Training records reflected staff completion of mandatory training requirements and management explained how they monitor staff completion.

The service has a recruitment system with minimum employment requirements and individual compliance is monitored through the human resources system.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 7(3)(d).

# Standard 8

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| Organisational governance | |  |
| 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. | Not 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 8(3)(d) and 8(3)(e), and as a result does not comply with Standard 8.

Requirement 8(3)(d):

The service has commenced implementation of new processes to identify and manage risk, however the Assessment Team report reflected that these are not fully implemented. The Assessment Team noted the Board’s active involvement and support to ensure successful improvement with risk management. The Board has approved recruitment of senior clinical and management positions and upgrades to internal medication systems.

Systems to document, monitor, and manage consumer risks were not consistent or effective. While some risks were managed well, such as skin integrity and wounds, others, in particular restrictive practices, lacked oversight and dignity of risk processes did not reflect appropriate levels of communication and risk mitigation. The service acknowledged improvement is required particularly in identified areas such as modified dietary requirements and where consumer choice and dignity of risk assessments have occurred.

The service has processes to identify abuse and reportable incidents, Serious Incident Report Scheme (SIRS) incident reports demonstrate reporting is now consistent with requirements. Management explained that processes have been strengthened to enable senior management oversight of complaints to prevent the occurrence of failure to report SIRS incidents. The Assessment Team noted that there is an incident management system in place however there was concern regarding the previous accuracy of reporting.

Requirement 8(3)(e):

The service is in the process of implementing improvements and change to the clinical governance framework. The framework includes a clinical governance committee, chaired by a member of the Board, and reporting to the Board with key clinical and safety performance indicators for trending and analysis. The Assessment Team noted actions by the service to improve clinical governance, however, these processes are not yet embedded and clinical data was not accurate. There was also no clinical oversight or reporting to the governing body to reflect consumers who are subject to psychotropic medications or restrictive practices.

The medication management system does not support monitoring of prescribed antimicrobials and the Assessment Team noted the multiple attending treating practitioners poses a barrier to monitoring of standardised best practice.

There was evidence of effective open disclosure where required.

The response to the Assessment Team report accepts the recommendations related to identified areas for improvement as well as a plan to address the deficits. I acknowledge the response and clarification related to the Clinical Governance Committee’s functions and previous reporting to the Board. I note the recent changes to management at the service and the active plan in place to ensure improvements are implemented. I find Requirements 8(3)(d) and 8(3)(e) non-compliant.

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