Performance

Report

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| Name: | Burrowa House |
| Commission ID: | 0260 |
| Address: | 79 Ford Street, BOOROWA, New South Wales, 2586 |
| Activity type: | Site Audit |
| Activity date: | 7 May 2024 to 9 May 2024 |
| Performance report date: | 5 July 2024 |
| Service included in this assessment: | Provider: 670 Boorowa Hostel Incorporated  Service: 276 Burrowa House |

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 Burrowa House (**the service**) has been prepared by Denise McDonald, 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 Site Audit 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 14 June 2024 and 25 June 2024
* the assessment team’s report for an assessment contact – Site conducted 21 March 2023 to 22 March 2023
* a Performance report dated 21 April 2023
* a Notice to remedy dated 20 June 2023

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not 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 | **Compliant** |
| **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.

* Requirement 3(3)(b) – The service must ensure staff implement effective practices to monitor, review and manage consumers following a fall.
* Requirement 8(3)(d) – The service must ensure its risk and incident management systems are embedded to ensure all incidents, including near misses are identified, reported and managed to reduce risk of harm and minimise reoccurrence.
* Requirement 8(3)(e) – The service must ensure its clinical governance framework is effective in identifying all consumers who are subject to environmental restrictive practices and the legislative requirements for those who are restricted, are met.

# Standard 1

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| Consumer dignity and choice | |  |
| 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

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements have been found Compliant, as:

Consumers and representatives said they felt staff treated consumers with dignity and respect and made them feel valued as an individual. Staff spoke about, and were observed to interact with consumers, in a respectful manner and with familiarity. Policies and procedures guided staff to ensure consumer diversity and inclusion was supported.

Consumers and representatives described how staff delivered care aligned to consumers' cultural preferences. Staff described how the consumer's background influences how they deliver day-to-day care and services. Care planning documentation evidenced specific cultural needs for consumers, such as the religious practices they wished to maintain.

Consumers and representatives said they had choice in how consumers care was delivered, and consumers were supported to decide if, and when, others were involved in their care decisions. Staff described how they encouraged consumers to be independent in their decision making by seeking their choices and preferences when delivering care. Care documentation reflected consumers’ care decisions, who is important to them, and what supports are required to maintain those relationships.

Staff were aware of the risks taken by consumers, and said they supported consumer’s wishes to live the way they choose. Consumers gave practical examples of being supported to take risks, such as having a lock on their door and confirmed risks associated with their safety had been discussed with them. Policies and procedures guided staff on supporting consumers’ rights of self-determination and to make informed choices.

Consumers confirmed they were kept informed through written information and verbal reminders. Staff described the ways in which information was provided to consumers in line with their needs, preferences and how communication was adjusted in response to sensory or cognitive deficits to ensure it was easy to understand. Activities calendars and menus were displayed to enable consumers to have choice over their daily activities.

Consumers gave practical examples of how staff respect their privacy by seeking consent to enter their room and closing doors while care was being delivered. Staff described their requirement to sign confidentiality agreements and knew not to discuss consumer information in front of others. Policies and procedures guided staff practice on maintaining consumer privacy and the circumstances in which consumers personal information was able to be disclosed.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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. | 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements have been found Compliant, as:

Requirement 2(3)(a) was found non-compliant following an assessment contact conducted in March 2023, as comprehensive assessments of consumer needs were not being undertaken and where risks were identified, care plans did not contain planned strategies to inform the delivery of safe and effective care for consumers. Additionally, risks to consumers were inconsistently identified across assessments, care plans and care documentation. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Consumers and representatives confirmed when consumers entered care consumers were assessed to inform the planning of the consumer’s care needs. Staff advised, a schedule embedded within the electronic care management system (ECMS), guides them on completing a range of assessments and in the development of the consumer’s interim and comprehensive care plans. Care documentation evidenced assessments were completed as scheduled with responsive strategies planned, however, staff had not considered whether consumer’s cognitive, sensory or manual dexterity assessment outcomes placed them at risk of inappropriate environmental restrictive practice. This is further considered under Requirement 8(3)(e) as it relates to deficits in clinical governance.

Requirement 2(3)(b) was found non-compliant following an assessment contact conducted in March 2023, as care documentation did not reflect consumer’s current goals, needs and preferences as elements of the consumer’s care plans were either not completed, vague in direction or had not been updated following changes. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Consumers and representatives advised consumer’s care goals, needs and preferences, including for advance care and end of life were assessed and discussed during entry and care plan reviews. Care documentation reflected consumer’s current assessed needs, their goals of care and their individual preferences, including whether they wished to receive advance care. Staff demonstrated knowledge of assessment and planning processes to ensure the current needs of each consumer were documented.

Consumers and representatives confirmed their involvement in the assessment and planning of consumers care, including during care plan reviews. Staff described assessment and planning of care was done in partnership with consumers and advised medical officers, specialists and allied health professionals contributed to assessment of the consumer. Care documentation evidenced regular care plan evaluations were conducted with the consumer, their chosen representative and included input from medical officers and allied health professionals.

Consumers and representatives said changes relating to care and services were communicated to them, staff provided further explanation if needed and they were offered a copy of the consumer’s care plan. Staff said outcomes of assessment and planning were communicated in various ways, including during monthly consumer reviews. Care documentation, including summary care plans, was observed to be readily accessible via the electronic care management system (ECMS), should consumers or representatives want a copy.

Requirement 2(3)(e) was found non-compliant following an assessment contact conducted in March 2023, as care plan review processes including the ‘resident of the day’ were not being completed as scheduled and when incidents occurred, consumer’s care needs were not reassessed. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Consumers and representatives confirmed consumers were reassessed and their care needs updated following a change in their condition. Care documentation evidenced care plans reviews had occurred as scheduled, with care needs and preferences revisited during ‘resident of the day’ processes. Policies and procedures guided staff practice in the assessment, planning and review of consumer’s care and service needs, however not all incidents had prompted review of the consumer’s care to determine if care strategies were effective. This is further considered under Requirement 8(3)(d) as it relates to effectiveness of incident management systems.

# Standard 3

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| Personal care and clinical care | |  |
| 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. | Not 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 Quality Standard is assessed as non-compliant, as one of the 7 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 14 June 2024 and 25 June 2024.

In relation to Requirement 3(3)(b), this requirement was previously found non-compliant following an Assessment Contact in March 2023, as consumers who experienced falls or had wounds, diabetes and catheters were not managed effectively. This Site Audit report contains recommendations that this Requirement remains non-compliant as consumer’s were not effectively managed following a fall.

For two named consumers, they each experienced a recent unwitnessed fall which occurred during the evening and there was no evidence to support post fall pain monitoring processes were implemented, the consumer was reviewed by an allied health professional or that monitoring for neurological decline was consistently performed, in line with organisational policy. While care documentation supported both consumers were seen by their medical officer within 24 hours of the fall, it did not support, for one consumer, the medical officer completed a post fall review or that their falls risk had been reassessed by staff. Care documentation confirms one consumer sustained a fractured rib as a result of their fall and was experiencing pain.

Management, who provides on-call clinical support when incidents happen overnight, confirmed they provided staff with post fall monitoring guidance following the incidents, and acknowledged the deficits in documentation of monitoring practices. Management advised they would undertake improvement actions including a review of falls oversight systems and staff would be reminded of their documentation responsibilities.

The providers response did not include any further commentary on the findings of the audit, however documentation was submitted including consumer’s post falls observation charting and medical officer review requests, to support some falls oversight improvement actions had been completed. A copy of the plan for continuous improvement was not submitted.

I acknowledge the observation charts, for another consumer who experienced a fall on 15 May 2024, supports actions to streamline documentation of neurological observation monitoring processes and staff were documenting these observations. However, I am not satisfied this action has been effective as the frequency at which staff have undertaken observations was inconsistent with large gaps exceeding 9 hours at times and not all elements included within neurological observation, were recorded. I also note only one observation evidenced the consumer had been assessed for pain and no other evidence to support pain monitoring was initiate, was submitted.

While documentation submitted supports some improvement actions have been undertaken or completed, I am not satisfied their effectiveness has been demonstrated to support high impact risks to consumer are effectively managed.

Based on the evidence before me, I find Requirement 3(3)(b) non-compliant.

In relation to the remaining 6 requirements of this Quality Standard, I find them compliant, as:

Requirement 3(3)(a) was found non-compliant following an assessment contact conducted in March 2023, as policies and procedures reflecting best practice clinical care had not been implemented to guide staff and deficits in management of wounds, chemical restrictive practices, medications, including antibiotics, and provision of personal hygiene were identified. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Consumers and representatives said consumers were receiving personal and clinical care which met their care needs and optimised their wellbeing. Staff understood how to deliver safe and effective clinical care and demonstrated knowledge of the care required by individual consumers, including to manage wounds, pain and changed behaviours. Care documentation evidenced individualised care was delivered to consumers in line with their planned care directives, however, it did not contain evidence of informed consent for chemical restrictive practices, including when this had been given verbally or identify any consumers who were subject to environmental restrictive practice. This is further considered under Requirement 8(3)(e) as it relates to the effectiveness of clinical governance.

Care documentation for a consumer who had recently passed away, evidenced the consumer was kept comfortable while nearing the end of life, through provision of regular care, administration of medication and their family were supported to spend time with them. Staff were knowledgeable of how to provide end of life care which ensured the consumer’s physical, emotional, and spiritual needs were met. Policies and procedures guided staff practice in delivering end of life care.

Requirement 3(3)(d) was found non-compliant following an assessment contact conducted in March 2023, as changes in consumer condition and clinical deterioration were not recognised in a timely manner and when concerns were identified staff responses to have the consumer reviewed were delayed. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Consumers and representatives said consumer’s condition was monitored and any changes were identified quickly. Staff confirmed implementation of processes used to monitor for consumers and knew when to escalate concerns to ensure the consumer was reviewed promptly. Care documentation evidenced regular monitoring of consumer’s weight, wounds and behaviour so that changes or deterioration in their clinical status were responded to in a timely manner.

Consumers and representatives felt the consumer's preferences and care needs were effectively communicated between staff, and with medical and health professionals involved in their care. Staff advised information about consumer needs, conditions, and preferences was shared through meetings, handover and via care documentation stored in the ECMS. Staff were observed to handover changes to consumers care between shifts.

Consumers and representatives said timely referrals were made providing access to a range of health professionals, as required. Staff demonstrated knowledge of referral processes and who they could refer consumer to as need arose. Care documentation evidenced referrals were completed and the consumer was reviewed promptly by medical officers, allied health professionals and specialists.

Consumers and representatives said staff were always observed to be practice hand hygiene and used personal protective equipment when attending to care. Staff understood application of precautions to prevent and control infection and the steps they could take to minimise the need for antibiotics. Policies and procedures guided staff in antimicrobial stewardship and infection control, including in the event of an infectious outbreak.

# Standard 4

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| Services and supports for daily living | |  |
| 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

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements have been found Compliant, as:

Consumers advised they were supported to engage in daily activities which enhanced their quality of life and met their needs, goals, and preferences. Staff said consumer’s daily living support needs were assessed upon entry and their preferences informed service provision. An activities calendar demonstrated a variety of group, and individual activities were scheduled.

Consumers and representatives said consumers were supported when they felt low, and their spiritual and psychological well-being were met. Staff were knowledgeable of consumer’s emotional support needs and confirmed spending one-on-one time with consumers if they became distressed. The activities calendar evidenced prayer groups and religious services are held on site.

Consumers and representatives said consumers were supported to do things which interest them, participate in the internal and external community and to keep in touch with people important to them. Staff said they assisted consumers to be ready on days they were known to be going out and helped consumers to make calls to families when required. Care documentation reflected who and what relationships were important to consumers, their interests and community connections.

Consumers said their needs and preferences were communicated effectively, as staff knew their dietary preferences. Care documentation and dietary profiles were observed to contain consistent information regarding, consumer’s food likes and dislikes. Staff described how changes are communicated between clinical, care and catering staff which ensured consumer’s daily living needs and preferences were known.

Consumers and representatives said they were referred to other organisations for additional support, as required. Staff confirmed a range of external services, such as volunteers and community groups, were available and their lifestyle program was supplemented through these arrangements. Care documentation evidenced consumers referrals were undertaken promptly and consumers were able to access additional services, as needed.

Consumers and representatives gave positive feedback on the quality and quantity of food being provided to consumers. Staff described meals are varied through a rotating menu, which is developed based on consumers’ feedback, their dietary needs and preferences. Meal services was observed to conducted in a timely and organised manner.

Equipment provided to consumers was observed to be safe, suitable, clean, and well maintained. Consumers reported having access to equipment, including mobility aids to assist them with their daily living activities and confirmed these were inspected regularly to ensure they were in working order. Staff understood their role in keeping consumers equipment clean and well maintained.

# Standard 5

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| Organisation’s service environment | |  |
| 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

The Quality Standard is assessed as compliant, as 3 of the 3 specific requirements were assessed as compliant. The Assessment Team recommended one of these requirements was not met, however I have come to a different view. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 14 June 2024 and 25 June 2024.

In relation to Requirement 5(3)(b), the Site Audit report did not raise any concerns with the cleanliness, safety, comfort or maintenance of the service environment, however, it was evidenced consumers free movement was restricted by the security measures placed at the front door which may impact some consumers ability to leave or re-enter the service as desired.

Management confirmed the front doors were always locked to incoming visitors or consumers returning from the community and additional lock up procedures were initiated at night to secure external facing doors to promote the safety of consumers. I have considered the potential impact of this as an unintentional restrictive practice under Requirement 8(3)(e) as it relates to deficits in clinical governance.

The providers response did not include any commentary on the findings of the audit, however documentation to support the lock up procedures was submitted. In addition, documentation supporting consumers and/or their representatives had acknowledged and provided consent to the security measures at the front door, was submitted.

I acknowledge consumers who were independent and wished to leave via the front door confirmed they were able to do so, and no consumers or representatives raised concerns regarding having to wait for staff assistance to gain entry to the premises, when returning from the community. I also note, external facing doors were secured, not locked and it was confirmed consumers who wished to access outdoor areas are night were able to unlatch the doors to exit, but no consumers had expressed a desire to do so. I consider this supports consumers were able to move freely, indoors, outdoors and were able to access all parts of their environment which supports compliance.

While, I have found consumers were able to move freely and had access indoors, outdoors and to the community, and acknowledge it is reasonable for security measures to be in place, I encourage the provider to continue their consideration of alternate security arrangements with a view to promoting consumers to regain entry to their home, without being reliant on others to open the front door for them.

Based on the evidence detailed above, I find Requirement 5(3)(b) compliant.

In relation to the remaining 2 requirements of this Quality Standard, I find them compliant, as:

Consumers and representatives said the service environment was welcoming, it felt like home, it was easy to understand, and consumers were encouraged to personalise their rooms. Staff advised when consumers enter care, they make them feel welcomed and understand the environment by taking them on a tour. Communal areas and outdoor areas were observed to be furnished in a home like style and promoted consumer interaction.

Consumers and representatives confirmed equipment and furniture was kept clean and safe. Furniture in communal areas was observed to be clean, in good condition and the call bell system was functioning properly, despite having missed its last scheduled inspection. Staff confirmed they regularly check fittings, including the calls bells, to ensure they were in working order and maintenance documentation evidenced inspection of most equipment was completed as scheduled.

# Standard 6

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| Feedback and complaints | |  |
| 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

This Quality Standard is assessed as Compliant as 4 of the 4 Requirements have been found Compliant, as:

Consumers and representatives said they felt safe and comfortable when providing feedback and complaints and were aware of the different mechanisms available to them to raise any concerns or suggestions. Staff said consumers gave feedback directly to staff, through surveys, at meetings and written complaints could be lodged via feedback forms or emails. Written material and information displayed encouraged consumers to provide feedback and to make complaints.

Consumers and representatives said they were aware of and knew they could access external advocates but preferred to raise concerns with staff. Management was knowledgeable of language and advocacy services available to support consumers, but staff were not, they advised all consumers spoke English and if an advocate was needed, the consumer would be referred to management for assistance. Posters and pamphlets displayed promoted consumers could access the Commission if they wished to lodge a complaint.

Consumers and representatives said actions were taken to resolve their complaints. Staff demonstrated knowledge of the principles of open disclosure and their actions in responding to complaints was guided by complaints management policies and procedures. Complaints documentation evidenced complaints were usually actioned immediately, however, for one complaint, follow up actions were not evident after initial investigations concluded and open disclosure had not been used.

Requirement 6(3)(d) was found non-compliant following an assessment contact conducted in March 2023, as feedback and complaints had not been consistently recorded or used to inform governance processes and what improvements were required to ensure the quality of care and services provided to consumers. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Continuous improvement documentation evidenced, feedback from various sources prompted actions to be added to the plan, which were monitored through to completion and evaluated with consumers to ensure planned actions had addressed their concerns. Consumers and representatives confirmed their feedback regarding consumers’ meals being served cold had resulted in the purchase of new kitchen equipment which had improved the temperature of meals. Staff described complaints documentation processes to ensure verbal and written feedback was managed consistently and enabled trends to be identified and actions planned to respond.

# Standard 7

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| Human resources | |  |
| 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. | Compliant |

Findings

The Quality Standard is assessed as compliant, as 5 of the 5 specific requirements were assessed as compliant. The Assessment Team recommended one of these requirements was not met, however I have come to a different view. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 14 June 2024 and 25 June 2024.

In relation to Requirement 7(3)(e), the Site Audit report evidenced annual performance appraisals for 50% of staff were overdue, with 3 staff confirming they had not completed a performance appraisal within the last 12 months. Two other staff confirmed their appraisal had not been completed, however, they advised they had worked at the service for less than 12 months.

Management confirmed performance appraisals were scheduled to be conducted annually. Management advised they were aware some staff had not had their performance formally reviewed; however continuous informal monitoring processes were in place to monitor the performance of staff. Management confirmed observations, probationary check-ins, feedback received from consumers, representatives and other staff, were used to assess staff performance, with any adverse incidents prompting the commencement of performance management processes.

Consumers and representatives did not raise any concerns regarding staff performance and management proposed all outstanding appraisals would be completed by July 2024.

The providers response included a staff appraisal register which was advised as either not presented during the audit or has since become available. The documentation substantiated most staff had completed their appraisals within the past 12 months. For those staff who were identified as not having a current appraisal these were overdue by less than a month, not yet due or unable to be completed as scheduled as they were on leave.

While I am satisfied, management’s proposed actions will address the completion of outstanding performance appraisals, I encourage the provider to continue to embed improvements in its documentation and information management practices to ensure actions taken are able to be monitored and documentary evidence is able to be produced to support compliance, when required.

Based on the evidence detailed above, I find Requirement 7(3)(e) compliant.

In relation to the remaining 4 requirements of this Quality Standard, I find them compliant, as:

Consumers and representatives felt there was sufficient staff to meet the care needs of consumers, with consumers reporting staff were quick to assist them. Most staff said there was enough staff and strategies were in place to ensure consumer care needs were able to be met in the event of unplanned leave, including when this was the one registered nurse, rostered overnight. Rostering documentation evidenced all shifts were filled, registered staff were continuously on site and care minute targets were being exceeded.

Most consumers and representatives said staff were kind, caring and respectful, however one consumer said on the odd occasion staff were not gentle when providing care, with investigations to occur in response to this feedback. Staff were observed to conduct their interactions with various consumers in a gentle manner and they spoke to consumers respectfully. Staff gave practical examples of use of tone, not raising their voices and understanding personal preferences as respectful behaviour.

Requirement 7(3)(c) was found non-compliant following an assessment contact conducted in March 2023, as competency of staff was not always assessed and deficits in staff knowledge were identified in post falls and wound management, responding to clinical deterioration, and personal care. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Management advised newly implemented staff position descriptions outlined the required qualifications of various staff roles, with staff required to demonstrate competencies, including for medication administration during orientation. Personnel records evidenced staff qualifications, professional registrations, and suitability to work in aged care was confirmed prior to commencement and monitored for currency. Staff confirmed completing orientation which included buddy shifts, mandatory training modules, followed by competency assessments. Staff confirmed they had been surveyed regarding potential deficits in knowledge, with results identifying no additional training was requested.

Requirement 7(3)(d) was found non-compliant following an assessment contact conducted in March 2023, as there was insufficient evidence to support staff were receiving adequate and ongoing training in aspects of the Quality Standards including restrictive practice, risk management and the Serious Incident Response Scheme (SIRS). This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is evidenced by:

* Management confirmed the scheduling and monitoring of staff education has been allocated to a dedicated position resulting in increased oversight and staff follow up if training has not been completed. Education records evidenced staff were scheduled to complete a range of mandatory and non-mandatory training modules, with all staff noted as having completed their assigned modules when scheduled. Staff demonstrated knowledge of, and knew their responsibilities, in relation to management of high impact/high prevalent risks, wound management, clinical deterioration, restrictive practices, incident management, open disclosure and infection control. However, deficits in clinical documentation, identifying restrictive practices, and reporting of incidents have been identified and have contributed to findings of non-compliance in Requirement 3(3)(b), Requirement 8(3)(d) and Requirement 8(3)(e).

# Standard 8

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| Organisational governance | |  |
| 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. | 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

The Quality Standard is assessed as non-compliant, as 2 of the 5 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 14 June 2024 and 25 June 2024.

In relation to Requirement 8(3)(d), this requirement was previously found non-compliant following an Assessment Contact in March 2023, as incident management systems were ineffective and clinical oversight of high impact, high prevalence risk was inadequate. This Site Audit report contains recommendations that this Requirement remains non-compliant as risk management processes have not identified when high impact/high prevalence risk policies and procedures have not been followed by staff. Additionally, not all incidents, including those of alleged psychological or emotional abuse, and sexualised behaviour towards staff have been reported.

While management advised oversight processes of reviewing progress notes, completing audits and monthly quality indicator data ensured all incidents were identified and reported, this was evidenced to not be effective as incidents reported through complaints and recorded in behaviour charting had not been identified. Management confirmed they were unaware of some incidents identified during the Site Audit and that staff were only required to report incidents of choking, pressure injuries, skin tears sustained from falls and falls, with other incidents discussed verbally at handover.

These oversight processes were also ineffective in ensuring high impact/high prevalence risks were managed effectively and deficits in staff documentation were not identified to reduce risk or future potential risk to consumers. This is supported by a finding of non-compliance in Requirement 3(3)(b).

The providers response did not include any further commentary in response to the findings of the audit, however documentation was submitted substantiating the transfer of incidents through clinical handover documentation. While I am satisfied this information is transferred between staff, I am not satisfied all incidents are identified, reported, collated and provided to the board to inform risk management decisions.

I am satisfied that the evidence presented within the Site Audit report is sufficient to demonstrate risk and incident management systems continue to be ineffective.

Based on the evidence detailed above, I find Requirement 8(3)(d) non-compliant.

In relation to Requirement 8(3)(e) this requirement was previously found non-compliant following an Assessment Contact in March 2023, as an operational clinical governance framework had not been fully established. This Site Audit report contains recommendations that this Requirement remains non-compliant as processes were not in place to ensure environmental restrictive practice was accurately identified, assessed and managed resulting in some consumers’ free movement being restricted without consent.

The Site Audit report evidenced security measures were in place at the service’s front door which had not been recognised as a potential environmental restrictive practice for consumers who did not have the cognitive or physical capacity to release the lock to exit the premises. Additionally, any person seeking to enter the premises, including consumers, was unable to do so, as the front door was permanently locked, with access only granted when staff physically opened the door.

Deficits in the clinical documentation practices of staff have been identified and these had not been identified through clinical monitoring processes, with staff to be reminded of their documentation responsibilities noted as an improvement action to be undertaken.

The providers response did not include any further commentary in response to the findings of the audit, however, documentation submitted evidenced most consumers and representatives have been made aware of how a locked door and the installed security systems impacts a consumer’s free movement and have upon explanation have provided their consent. The Site Audit report brought forward assessment of consumers, and the development of behaviour support plans was in progress.

While I acknowledge the corrective actions taken by the provider, I consider these will take time to embed and demonstrate their sustainability and effectiveness in ensuring the use of restrictive practice is minimised and accurate records of clinical care are maintained.

Based on the evidence detailed above, I find Requirement 8(3)(e) non-compliant.

In relation to the remaining 3 requirements of this Quality Standard, I find them compliant, as:

Consumers and representatives confirmed they were engaged in the design and evaluation of care and services through verbal feedback and via lodgement of complaints. Management advised, a consumer advisory body is in the process of being established, with consumers and representatives contributing to service operations, through consumer meetings, surveys and case conferences to review care. Meetings minutes evidenced consumers were encouraged to make suggestions on potential upcoming events and activities.

Documentation evidenced the composition of the Board included executive and non-executive members, with relevant skills and clinical experience to ensure the promotion of safe, inclusive, quality care and services. Management described the organisational structure and hierarchy, including monthly reporting and reciprocal communication practices between different levels of management informed the board of the service’s performance against the Quality Standards. Meeting minutes evidenced clinical data and audit outcomes were submitted to the Board for review, however, data reported to the board was identified to omit various incidents as these were not reported by staff. This is further considered under Requirement 8(3)(d) as it relates to the effectiveness of risk and incident management systems.

Requirement 8(3)(c) was found non-compliant following an assessment contact conducted in March 2023, as organisational information management, workforce, continuous improvement, feedback and complaints governance systems were found to be ineffective. This Site Audit report evidenced actions to address the non-compliance have been taken and this Requirement is now found compliant. This finding is supported by:

* Management and staff demonstrated knowledge of information management, continuous improvement, feedback/complaint management policies and procedures, with documentation evidencing, procedural information was translated into practice. Management advised workforce governance had been strengthened with position descriptions and processes to monitor training completion implemented, with staff interviews demonstrating staff understood their roles and responsibilities, however, processes to regularly monitor staff performance had not been effectively documented which is further considered under Requirement 7(3)(e).

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