Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Cameron Park Care Community |
| Commission ID: | 0895 |
| Address: | 60 Northlakes Dr, CAMERON PARK, New South Wales, 2285 |
| Activity type: | Site Audit |
| Activity date: | 13 November 2023 to 15 November 2023 |
| Performance report date: | 19 December 2023 |
| Service included in this assessment: | Provider: 3061 DPG Services Pty Ltd  Service: 5869 Cameron Park Care Community |

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 Cameron Park Care Community (**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 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 15 December 2023
* other information and intelligence held by the Commission in relation to the performance of the service

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **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 | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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

Consumers said they were treated with dignity, respect and staff made them feel valued. Staff spoke about, and were observed interacting with, consumers in a respectful manner. Care documentation contained information specific to consumers' background, diversity, culture and preferences.

Consumers and representatives reported staff provide care consistent with consumer’s cultural preferences. Staff demonstrated knowledge of how a consumer's culture influences how they care or services. Care documentation evidenced cultural needs were considered in planning of care strategies.

Consumers said they are enabled to make decisions about how care is delivered, who is involved in their care decisions and can sustain relationships of their choosing. Staff advised consumers are encouraged to make decisions about their meals and participation in scheduled events. Care documentation evidenced consumers in intimate relationships were assisted to spend time together.

Consumers advised they were supported to engage in activities which presented a safety risk, including smoking cigarettes. Policies and procedures guided staff practice including enabling consumers to live the life they choose. Staff knew the strategies to support consumers to remain safe when undertaken activities of their choosing, however, not all decisions regarding risk such as refusing to be referred to health professionals, had been documented. This has been considered further under Requirement 3(3)(f).

Consumers and representatives confirmed information provided is current and communicated in ways that is easy to understand, including for people who speak other languages. Staff described methods used to keep consumers with cognitive and sensory impairments, informed. Noticeboard were observed to display current and accurate information on activities, meals, and the newsletter.

Consumers said staff are respectful of their privacy and had no concerns regarding the confidentiality of their information. Staff demonstrated knowledge of and were observed implementing practices, such as knocking, before entering rooms and locking nurse’s stations to ensure consumer privacy.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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

Staff described, the initial and ongoing assessment processes used to identify risk to consumer’s health and demonstrated knowledge of, how this informs the development of intervention strategies compiled within the consumer’s care plan. Care documentation evidenced, validated tools were used to assess skin integrity, continence, nutrition and mobility risks. A checklist, policies and procedures guided staff in the completion of assessment and care planning, however for some consumers risks of restrictive practice and impaired vision had not been identified.

Care documentation evidenced, consumers’ needs, goals and preferences, including for advance and end of life (EOL) care had been identified and noted, however, one consumer’s care plan was updated, as it did not contain their current dietary preferences. Consumers said they had discussed and provided to staff their preferences for EOL care. Staff were familiar with consumers documented needs, including to manage pain and knew which consumers did not want advance care.

Care documentation evidenced the involvement of health professionals and specialists in the care of the consumer. Staff described how they actively collaborate with consumers, representatives and others, to ensure consumer-centred care planning occurs, with completion of care consultations monitored. Consumer and representatives advised their level of engagement in assessment and care planning, had improved recently due to the introduction of a new management team.

Consumers and representatives said they have access to consumer’s care plans; staff explain clearly and clarify clinical matters if needed, with communication noted as having recently improved. Staff said and care documentation evidenced, representatives were informed of assessment outcomes. Care plans, including summary care plans, were observed to be accessible via the electronic care management system.

Consumers and representatives said any required changes to consumers care plans are identified and addressed in a timely manner. Staff described care documentation was reviewed every 4 months. Care documentation, evidenced, care interventions were routinely evaluated and updated in response to identified changes or incidents occurring, however, for one consumer, their behaviour support plan had not been reviewed in response to escalation of verbal behaviours.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | 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 recommended Requirement 3(3)(f) was not met. I have considered the assessment team’s findings; the evidence documented in the site audit report and the provider’s response, submitted on 15 December 2023, and have found:

The Site Audit report evidenced, most consumers and representatives said consumers were referred to allied health professionals and medical officers, as needed. Care documentation supported staff had appropriately referred, a consumer to speech pathologist following a choking incident, with the referral actioned on the same day, and review of the consumer occurring, within 7 days.

Staff demonstrated knowledge of the range of allied health professionals available to support consumers, and described referrals are undertaken in consultation with the medical officer. Management advised policies and procedures were available to support staff, confirming recent changes to referral procedures had been made.

However, for 2 consumers, care documentation indicated some referrals did not occur in line with the service’s policy or when referrals were declined by their representative, the refusal of referral was not documented.

For one consumer, care documentation supported staff had identified they had experienced weightloss over consecutive months and consulted with the consumer’s representative regarding referring the consumer to a dietician, which was refused. Care documentation supported the consumer continued to lose weight, but no further referrals were arranged. While the consumer had experienced recent weightloss, staff advised the consumer was currently eating well and the consumer’s representative advised the consumers weightloss had been managed well.

For another consumer representative, they were informed during an oncology appointment in August 2023, palliative care specialists would become involved in the consumer’s EOL care, to support with pain management. The representative advised and staff confirmed, the consumer had experienced significant deterioration during the weeks prior to the Site Audit, with the consumer’s medical officer, approached to prescribe EOL medications. The representative confirmed they had raised with clinical staff the need for palliative care involvement; however, no referral was evident in the consumer’s care documentation.

The provider’s response refuted the findings of the Site Audit, contained clarifying information and additional documentation including consumer’s clinical care extracts, education records, referral and palliative care procedures.

For the consumer losing weight, care documentation evidenced, the consumer was for comfort measures to maintain their quality of life only. The consumer’s weightloss had been discussed with the consumer’s representative, who was not concerned. Care documentation supported the consumers body mass index, was above the healthy weight range, despite the recent weight loss.

Care documentation also evidences an ongoing consultation process between staff and the consumer’s representative, as they were again approached regarding referring the consumer to a dietician, as the consumers weight decreased further in October 2023, following an acute illness. The dietician was noted to have reviewed the consumer within 7 days, with the consumer’s weight recorded as now being within the healthy weight range and recommendation for nutritional fortification and supplementation made.

In relation to access to palliative care specialists, the response confirms the consumer was referred to palliative care services, in January 2023 by the oncology unit, to alert them the consumer may need support, when they enter the terminal phase. The palliative care procedure evidenced palliative care specialists are only approached when a consumers EOL symptoms were complex or challenging.

While the consumers representative and staff had identified deterioration in the consumer and had raised the potential commencement of EOL medications, care documentation submitted, evidenced the consumer was denying pain when reviewed by the medical officer, and was tolerating oral ingestion of pain relief medications, therefore, the administration of EOL medications through an infusion pump were not clinically indicated at the time. Care documentation supports when the consumer became nauseous, refused oral medications and was observed grimacing, they were prescribed EOL medications, with care documentation also supporting the consumer was not experiencing complex or challenging symptoms as they were noted to be settled and remained comfortable.

Based on the detailed evidenced above, I am persuaded by the evidence in the Site Audit report which demonstrated staff acted quickly when consumers needed review by allied health professionals, and care documentation submitted by the provider, which supports referral of consumers to health and medical professionals is undertaken, when clinically indicated, it is completed in consultation with the consumers, their representative and their medical officer and these referrals may be refused, however when agreed the service has undertaken these referrals promptly, which supports compliance with this requirement.

I note the service has identified improvement opportunities exist for documenting, when active input from specialist services is not required or the risk of refusing referrals is discussed with representatives, however I do not consider this supports a systemic failure in referral processes.

Therefore, I find Requirement 3(3)(f) is compliant.

I find the service is compliant with the remaining 6 Requirements of Quality Standard 3, as:

Staff were knowledgeable of how the delivery of care was tailored to meet individual consumers needs and preferences. Care documentation generally evidenced management of consumer’s pain and wounds according to directives, however some consumers, with a chemical restrictive practice applied, had not been recognised, resulting in informed consent being obtained based on feedback given during the audit. Consumer and representatives gave mostly positive feedback regarding the delivery of personal and clinical care, with noted improvements to care provision in recent months.

Staff were knowledgeable of high-impact and high-prevalence risks to consumers and described mitigation strategies implemented in response. Consumers and representatives said these interventions in place for consumers was effective. Care documentation reflected strategies to support the management of high impact high prevalence risks.

Consumers and representatives gave positive feedback about how care to consumers nearing EOL was provided, however, thought palliative care specialists should be involved. Staff described how consumer comfort was ensured through continence, oral and pressure area care. Policies and procedures guided staff practice in providing palliative and EOL care.

Consumer’s care documentation evidenced deterioration or changes in condition were generally identified and responsive actions were prompt. Consumers said when there was decline in condition, they were reviewed and transferred to hospital, when needed. Staff demonstrated knowledge of a range of signs, related to deterioration, and understood the need for quick escalation, if these signs were detected.

Consumers and representatives said information regarding the consumer's care was effectively shared. Care documentation contained adequate information to support staff and others to understand consumer’s needs, the vision status of one consumer was corrected during the audit. Staff and allied health professionals confirmed an electronic care management system is used to access care information and changes are communicated to staff via handover processes.

Consumers and representatives confirmed staff routinely perform hand hygiene and implement practices to control transmission of infection. Staff understood precautions to prevent infection and the steps they could take to minimise the need for antibiotics. Policies and procedures guided staff practices to reduce antibiotic resistance and in response to an infectious outbreak.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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

Consumers said their independence is supported, and they receive the services they need for their activities of daily living. Care documentation evidenced consumers service and support needs and preferences, including for mobility and attendance at activities, had been identified and recorded. The activity calendar contained activities scheduled in response to the diverse needs of consumers.

Consumers and representatives said consumer’s emotional, spiritual and psychological needs were met. Care documentation evidenced strategies used to support consumer’s mental and emotional health. Staff described various ways consumers emotional and spiritual needs were supported through companion pets and chapel services.

Consumers and representatives said consumers were supported to participate in activities, within the service and external community, and to keep in touch with people important to them. Staff gave practical examples of how they assisted consumers to mobilise and dialling family members phone numbers of support provided. Care documentation included consumer interests and contact details for friends and family.

Consumers and representatives said information about consumer’s support needs is communicated well. Staff described information is shared between staff via handovers and through the electronic care management system. Care documentation evidenced adequate information to support effectively sharing of information between staff and health professionals involved in care of the consumer.

Consumers and representatives said if consumers needed to be referred for additional services or support this was done in a timely manner. Care documentation evidenced consumers were appropriately referred to psychologists and volunteers when social support needs were identified. Staff described consumers were also able to be referred for pastoral care.

Consumers said the quality of the meals was good, however, one consumer said there was not enough variety, and the portion sizes were not satisfactory. Care documentation evidenced, consumers dietary needs and preferences were identified, recorded and shared between staff, who worked with consumers to meet their dietary needs, when negative feedback was received. Meal service was observed with meals provided to consumers in a timely manner and staff were available to assist consumers, as required.

Consumers said they could access equipment, including mobility aids which were suitable for them. Staff described processes used to ensure equipment was safe, clean and in good working order. Equipment was observed to be clean and in good condition.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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 service environment was observed to be welcoming, with consumers and representatives saying the environment was easy to understand and corridors were kept free of hazards to promote independent mobilisation. Staff described the layout of the furniture and availability of communal lounge areas encourages social interaction.

Consumers reported the service was clean and no malodour was present. Staff described maintenance, laundry and cleaning duties were scheduled to ensure routine completion, with documentation evidencing all tasks were up to date. Consumers were observed moving around freely and using indoor and outdoor areas, as they wished.

Consumers confirmed, equipment was cleaned regularly. Furniture in communal areas was observed to be clean and in good condition. Fittings such as call bell systems, were observed to be in working condition and staff knew how to report faults and request repairs.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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

Consumers and representatives described they are able to provide feedback or make a complaint, via feedback forms, directly to staff, and electronically. Staff advised consumers were encouraged to give feedback and make suggestions through various means, including consumer meetings. Feedback forms and lodgement boxes were readily accessible to consumers.

Consumers and representatives demonstrated knowledge of the language, external complaints, and advocacy services available to them. Meeting minutes evidenced an advocate had presented at a consumer meeting. Posters and brochures on external complaints agencies was displayed and translated copies were also available for consumers of different linguistic backgrounds.

Consumers and representatives said the new management team, responds to and resolves their complaints or concerns quickly. Staff understood the principles of open disclosure and how these are applied when things go wrong. Complaints documentation evidenced apologies are given and consumers and/or representatives are involved in resolution, which was achieved promptly.

Consumers and representatives gave positive feedback on how their concerns had been used improve the quality of care and services. Management gave practical examples of the actions taken to improve meals and the dining experience, which had been incorporated into the plan for continuous improvement for monitoring. Complaints documentation evidenced feedback from various sources was tracked to identify trends requiring action.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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 assessment team recommended Requirements 7(3)(a) and 7(3)(e) were not met. I have considered the assessment team’s findings; the evidence documented in the site audit report and the provider’s response and have found:

In relation to Requirement 7(3)(a), the Site Audit report evidenced the allocation of staff was insufficient as many consumers and representatives said the safety and quality of the care or services received by consumers was being negatively impacted. This included at mealtimes, when consumers required staff assistance with toileting or mobilising and when they required support to maintain their social or emotional health.

In relation to meals, one consumer, raised concerns of staff appearing rushed when serving, and a consumer representative, felt that consumers were left to sit in front of cold meals, as there was insufficient staff to assist. However, the Site Audit report also evidenced, the lack of staff assistance, had been raised with and resolved by management, to the representatives’ satisfaction.

For one consumer, they advised they call for toileting assistance, at night, earlier than it was required, as on occasions, staff take longer to respond and for another consumer, their representative felt, the frequent number of falls sustained, was directly attributed to staff not responding to the consumers call bell and them, mobilising independently out of impatience.

Call bell monitoring data supports there were instances, where consumers have waited for longer than the 10-minute benchmark set by the service, with extended call bell response times linked to 2 falls, for the consumer. Call bell audit reports, from July 2023, also included commentary from consumers regarding their dissatisfaction with staff response times.

Another consumer representative raised concerns regarding staffing within the memory support unit, particularly on weekends, which resulted in the rostered staff, not being able to have one on one interactions with consumers, impacting their social and mental health.

Staff also advised of being rushed, unable to respond to call bells promptly and confirming they were unable to interact with consumers individually, however, were aware of recruitment activities to increase the staffing pool and had been liaising with management, regarding transitioning to a new model of care.

Rostering documentation evidenced a registered nurse was continuously on duty and strategies were in place to fill unplanned leave, however, on review of rostering documentation 29 shifts were identified as unfilled.

The provider’s response refuted the findings of the Site Audit and submitted further clarifying information explaining changes made to their planned roster, the current recruitment strategies, the upskilling of staff to implement a new model of care and training provided to staff on meal service routine. Additionally, care documentation for the named consumers and documentation supporting the implementation of improvement actions as well as new actions, to systematically manage unplanned leave and to monitor staff assistance was also submitted.

The response confirms the service operates from a base roster with the same number of staff rostered on weekends as there is on weekdays. While rostering documentation supported 29 shifts were not filled, this was for the number of staff needed, when all beds were filled and in response to having up to 4 vacancies, management had chosen not to fill these shifts based on reduced operational requirements.

For the named consumers, documentation submitted for the consumer who had had falls, evidences them to be independent, and following the prescribing of psychotropic medications in response to suicidal ideation, they had experienced increased falls due to reduced cognition and mobility status, rather than the falls being attributed to delayed staff response. The consumer has not had any further falls since the strength of the medication was reduced.

For the consumer who calls for assistance, in anticipation of their toileting needs, there was no evidence to support this had a negative impact on the consumer, as there were no falls incidents or episodes of incontinence documented and in relation to staff not being able to support consumers individual interactions needs, documentation supplied evidenced staff had had 40 individual conversations with the consumer and the consumer had participated in 38 different activities to support their social and emotional needs.

While staff have said they were busy and they were unable to respond to consumers call bells promptly, call bell monitoring documentation supports, current improvement actions of recruiting additional staff, redistributing workloads and increased monitoring, had been effective in reducing the length of time taken by staff to respond to consumers.

I consider the documentation submitted by the service supports workforce planning strategies and documented improvement actions have been effective in responding to historic consumer dissatisfaction, noted in July 2023.

Based on the detailed evidence above, I consider that while consumers and representatives have raised some concerns, there is insufficient evidence to support the number and mix of staff was impacting their care or service provision in a negative way. This is also supported by the Assessment Team who recommended all requirements relating to the delivery of care and services were met.

Therefore, I find Requirement 7(3)(a) is compliant.

In relation to Requirement 7(3)(e), the Site Audit report evidenced staff performance was monitored and reviewed through informal observation of staff practice and when breaches to staff code of conduct were identified, performance management processes were initiated. Staff were aware of performance monitoring systems, they advised the service was responsive to organising additional training when required, and some confirmed their performance had recently been appraised, or was scheduled to occur in coming weeks. However, for most of their workforce, their last formal annual performance review, occurred in 2021.

The provider’s response confirms they had self-identified the omission to complete formal staff appraisals, when a new management team commenced in October 2023 and had commenced remedying this deficit, through a planned improvement action. The provider also advised a large proportion of the workforce had only commenced employment within the preceding 12 months, therefore, their performance reviews were not yet due.

For those staff due an appraisal, the provider has confirmed 61% of these have now been completed, with the remaining 39% scheduled for coming months.

The response also clarified the various ways in which staff performance is continually monitored including through consumer feedback, meetings and surveys, which also all provides a mechanism for staff to raise any additional education or training required. The provider’s response and the Site Audit report contained numerous practical examples of staff professional development being supported.

The Site Audit report and the response also both evidenced, when staff performance issues have been identified, this had resulted in training being provided and performance conversations with staff, having occurred.

While formal appraisals have not been conducted, I note the Site Audit report does not contain any significant concerns with the competency, knowledge or performance of current staff, to support the informal performance monitoring processes, have been ineffective as there is evidence to support performance management processes have been initiated, when issues with staff performance were identified.

Based on the detailed evidence above, I have placed weight on and consider the response provided and examples contained within the Site Audit report, are sufficient to determine that the provider has processes in place to monitor, manage and review the performance of each member of the workforce and while formal appraisals may not have been conducted as scheduled, rectification actions have been effective in redressing this.

Therefore, I find Requirement 7(3)(e) is compliant.

I find the service is compliant with the remaining 3 Requirements of Quality Standard 7, as:

Consumers and representatives said staff were kind, caring, respectful and gentle. Staff were observed to greet consumers by their preferred name and demonstrated knowledge consumer’s individual needs and identity. Policies, procedures and the staff handbook guided staff practice to deliver culturally inclusive care.

Consumers and representatives said staff know what they are doing. Management described staff competency is assessed through orientation process and assessments following training. Position descriptions evidenced key competences and requirements for each role were identified and monitored for staff attainment.

Most consumers and representatives said they thought staff were well-trained to deliver care and services. Management advised staff are required to complete mandatory and additional training assigned for their roles. Education records evidenced staff had been trained in open disclosure, serious incidents, restrictive practices and infection control.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | 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

The assessment team recommended Requirement 8(3)(c) was not met. I have considered the assessment team’s findings; the evidence documented in the site audit report and the provider’s response and have found:

The Site Audit report evidenced effective systems were in place to govern the management of information, continuous improvement, feedback and complaints and financial processes. However, workforce governance and regulatory compliance was not effective as the number of staff was allocated was insufficient to meet consumer needs, staff performance wasn’t being reviewed and deficits had been found in compliance with regulations when restrictive practices had been applied for 2 consumers.

The providers response describes strategies used to plan the allocation of and monitor the performance of the workforce and I have found this supports compliance with Requirements 7(3)(a) and Requirements 7(3)(e).

In relation to regulatory compliance, I have also found there were systems in place to monitor for and respond to, changes in legislation as the service has recognised their responsibilities in needing to meet the new care minute targets and has altered their roster accordingly.

The response included the submission of care documentation for the 2 named consumers, used to support deficiencies in compliance with the restrictive practice requirements outlined in the *Quality of Care Principles 2014*. Care documentation demonstrated chemical restrictive practices were effectively identified upon entry or recommencement of medication, with consent obtained.

Care documentation submitted also evidenced compliance with requirements to monitor, review and minimise restrictive practice, as it evidenced the service had conversations with the consumers representative to cease the medication, when behaviour charting showed behaviours of concern were not being exhibited.

Whilst the Site Audit report identified behaviour support plans were not in place, the providers response confirms for one consumer, behaviour charting had commenced and for the other consumer, behaviour assessment supporting the need for the restrictive practice had been completed, however the workflow to generate the behaviour support plan had not been completed within the electronic care management system.

Based on the detailed evidence above, I am persuaded that organisational governance systems have been effective as the provider’s response has demonstrated how they have met the legislative requirements for restrictive practice and how the workforce is governed.

Therefore, I find Requirement 8(3)(c) is compliant.

I find the service is compliant with the remaining 4 requirements of Quality Standard 8, as:

Consumers and representatives said management and the governing body provided continuous updates and held forums for feedback. Management said a variety of mechanisms were in place to ensure consumers provided input and enabled to make decisions about the care and services provided to them. A consumer committee was established, and meeting minutes evidenced their involvement in the design and evaluation of care and services.

Management described an organisational structure and hierarchy, with the Board being accountable for the delivery of care and services. Management said the Board monitors the quality of services through monthly reports against key performance indicators. Management advised audits against the Quality Standards are scheduled monthly with the Board using those results to drive improvements.

Management demonstrated understanding of the high impact and high prevalence risks associated with the care of consumers, and how the service safeguards risk, with prevalence of incidents such as falls, weightloss and medication errors monitored. Policies and procedures supported risk-taking enabling consumers to live their best life. Staff understood their roles and responsibilities in response to reportable incidents.

A clinical governance framework, including policies, and guidelines on antimicrobial stewardship, minimising the use of restraint and open disclosure was in place. Management and staff demonstrated knowledge of how these policies and procedures were applied in the delivery of care and services, including apologising when things went wrong, using non-pharmacological strategies to reduce the need for antibiotics and they need for restrictive practices to be used as a last resort.

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)