Performance

Report

**1800 951 822**

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| Name of service: | Chaffey Aged Care |
| Service address: | 2 Main Avenue North MERBEIN VIC 3505 |
| Commission ID: | 3782 |
| Approved provider: | Rural Care Australia Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 16 August 2023 to 17 August 2023 |
| Performance report date: | 20 September 2023 |

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 Chaffey Aged Care (**the service**) has been prepared by D. Fekonja, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 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 |

Findings

The service was found non-compliant in Requirement 2(3)(a) following a Site Audit conducted from 30 March 2023 to 1 April 2023. The service did not demonstrate assessment and care planning considered risk. The service has implemented several actions in response to the finding of non-compliance. These include:

* The implementation of a 6-monthly care plan and assessment review for all consumers and the creation of an assessment and charting matrix to support clinical staff in undertaking care plan and assessment reviews.
* The introduction of a ‘Care recipient of the day’ (CRD). This involves the review of a consumer each month, whereby the consumer is monitored throughout the day, their room tidied, representatives contacted, and their care file reviewed, in line with the service’s new CRD policy.

During the Assessment Contact conducted from 16 August 2023 to 17 August 2023, the service demonstrated assessment and care planning for consumers is individualised, considers risk, and reviewed every 6 months and or when changes occur.

Five of 5 consumers and/or representatives are confident that assessment and care planning consider the risk to the health and well-being of consumers. Four clinical staff demonstrated knowledge of consumers’ risk and their specialised care needs. Care planning documentation reflects the outcome of risk assessments undertaken in relation to pain, skin integrity, and falls.

Based on the information summarised above the service has made necessary improvements to its assessment and planning processes and is compliant with this Requirement.

# Standard 6

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| Feedback and complaints | |  |
| 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 |

Findings

The service was found non-compliant in Requirement 6(3)(b) following a Site Audit conducted from 30 March 2023 to 1 April 2023. The service did not make consumers aware of advocacy services and external methods for raising complaints. The service has implemented several actions in response to the finding of non-compliance. This includes:

* An update to the consumer handbook to include contact information for external complaints and advocacy services.
* The display of posters and pamphlets at the entry of the service, with contact details and information about the Aged Care Quality and Safety Commission and external advocacy services available to consumers.

During the Assessment Contact conducted from 16 August 2023 to 17 August 2023, 2 of 3 consumers and/or representatives said the service includes details of external advocacy and complaint services within the admission pack they receive. One consumer was not aware of other services to raise complaints/feedback. Staff were aware of the external methods for raising feedback and complaints. A representative from the elder rights advocacy is to run education sessions for staff and consumers about their services on 31 August 2023.

There are pamphlets and posters displayed at the entrance of the facility outlining contact details for the Aged Care Quality and Safety Commission, older person advocacy network, and translating and interpreting Service.

Based on the information provided in the assessment contact report I find that although one consumer was not aware of the external advocacy and complaint services this information could be easily located within the service or staff would be able to provide this information.

I find the service compliant with this Requirement.

# 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)(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 service was found non-compliant with Requirements 7(3)(a), 7(3)(d), and 7(3)(e) as the number and mix of members of the workforce did not enable the delivery and management of safe and quality care and services. Not all staff had undertaken mandatory training in the Serious Incident Response Scheme (SIRS) and regular assessment, monitoring, and review of the performance of each member of the workforce was not undertaken.

The service has increased the number of casual staff and is actively recruiting for more permanent staff including offering traineeships to people from the local community. There are daily roster monitoring, ongoing recruitment, and workforce planning meetings to ensure sufficient staffing at the service. Shift times have been changed to enable an increase in clinical staff presence at the service. A new call bell system has been installed and call bell audits and subsequent investigations are being undertaken by management, to ensure the call bell response times remain within the service’s benchmark standards. Consumers and their representatives are satisfied with staffing levels and staff were available when consumers required assistance.

The service has provided the training calendar to staff and training is offered face to face and mandatory modules including SIRS training are offered online. The service is monitoring the training completion data and reminders for overdue training are sent to staff. The service has provided a good range of education sessions to staff at orientation and for regular and agency staff. Staff are satisfied with the training opportunities and feel supported to deliver safe and effective care. Consumers and representatives were satisfied staff have the qualifications, knowledge, and skills to deliver effective and timely care and services.

The service has appointed a new People and Culture manager who is responsible for staff performance monitoring and appraisals. The service has commenced implementing a systematic appraisal process and staff are invited to participate and create an appraisal schedule. Reminders are being sent to staff whose appraisal is overdue. Staff confirmed they participate in annual appraisals and described how this is used to identify training needs and professional development. The service has committed to completing 100% of staff appraisals.

Feedback provided in relation to staff is discussed directly with the relevant staff member and a note is included in their file. Training and development needs are identified from this discussion and further performance management action taken if the issues continue.

Based on the information provided in the assessment contact report and summarised above I find the service compliant with Requirements 7(3)(a), 7(3)(d), and 7(3)(e).

# Standard 8

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| Organisational governance | |  |
| 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 service was found non-compliant in Requirement 8(3)(e) following a Site Audit conducted from 30 March 2023 to 1 April 2023. The service did not demonstrate a clinical governance framework in relation to minimising the use of restraint.

The service has implemented actions in response to the non-compliance which are contributing to improvements. This includes:

* The development of an organisational clinical governance framework.
* A review of the service’s restrictive practices policy.

During the Assessment Contact conducted from 16 August 2023 to 17 August 2023, the service demonstrated it has clinical governance frameworks in place that provide an overarching monitoring system for clinical care incorporating antimicrobial stewardship, minimising the use of restrictive practices, and open disclosure. The service communicated the framework to staff in a range of methods adapting it to suit the different staff roles. Staff were able to describe how they use open disclosure and employ antimicrobial stewardship when infections are identified. Staff described how they utilise non-pharmacological interventions prior to the use of the chemical restrictive practice.

The service monitors their systems for clinical care by reporting from the director through the clinical governance sub-committee to the Board

The Assessment Team reviewed policies relating to antimicrobial stewardship, restrictive practices, and open disclosure.

Based on the information provided I find the service now has a clinical governance framework in use that is understood by staff. The service is compliant with this Requirement.

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