Performance

Report

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| Name: | Corpus Christi Community |
| Commission ID: | 3138 |
| Address: | 855 Mickleham Road, GREENVALE, Victoria, 3059 |
| Activity type: | Site Audit |
| Activity date: | 30 August 2023 to 1 September 2023 |
| Performance report date: | 19 October 2023 |
| Service included in this assessment: | Provider: 2959 Corpus Christi Community Greenvale Incorporated  Service: 1897 Corpus Christi 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 Corpus Christi Community (**the service**) has been prepared by Katherine Richards, 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 consumers, representatives, staff, management, and others; and
* the provider’s response to the Assessment Team’s report received 6 October 2023

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not 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 | **Not 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 2(3)(a): The provider ensures assessment and planning is undertaken for and with consumers who choose to exercise dignity of choice to identify risks and inform safe management strategies.
* Requirement 7(3)(d): The provider ensures staff are required to complete training linked to the Quality Standards. The provider ensures staff are supported with adequate time and resources to complete relevant training and that training completion is monitored by the service.
* Requirement 8(3)(c): The service ensures deficits in organisational governance systems for regulatory compliance, workforce governance and information management are rectified, and continuous improvement actions provided to the Commission are implemented in a timely manner.

# 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 assessed as Compliant.

**Requirement (3)(d)**

The Assessment Team recommended Requirement (3)(d) in this Standard not met, as they were not satisfied each consumer is supported to take risks to enable them to live the best life they can. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Risk assessments had not been undertaken for consumers choosing to leave the service independently, including for some consumers with a history of alcohol dependence choosing to consume alcohol outside the service’s premises.
* Management described the service as an ‘open facility’, allowing consumers to leave freely with alcohol consumption prohibited on the premises.
* Staff were aware of consumers leaving the service independently, with a register for consumers to use to sign out and in of the service, and if the consumer does not return as expected they are contacted on their mobile phones with escalation to police and local hospitals if there is no response. In 2023, there have been 2 incidents of consumers failing to return.

The provider’s response states they recognise improvements to be made to risk assessment processes, and has submitted the following information, evidence, and intended improvement actions in relation to deficits identified by the Assessment Team:

* Developed a risk assessment for consumers undertaking independent outings and consumption of alcohol.
* Implemented supportive actions within the continuous improvement plan to ensure all impacted consumers have necessary assessment undertaken and incorporate assessment within admission process.
* Arranged medical review to assess suitability and ability for all consumers wishing to drive.

I have considered the information in the Assessment Team’s report and the provider’s response and have come to a different finding. Consumers said they felt supported to undertake activities including those involving risk, staff were aware consumers leaving the service independently and had some monitoring processes and strategies to follow if the consumer did not return in a timely manner. There is limited information relating to the impact on safety for consumers drinking alcohol beyond the absence of risk assessments. I find the service supported consumers to live their best lives, including taking risks. However, I find there were deficiencies in assessment and planning, including failing to demonstrate risks had been discussed with consumers to make informed choices and understand management strategies for safety. I find this evidence aligns better to Standard 2, Requirement (3)(a), and have considered it within my decision for that Requirement.

**In relation to all other Requirements**

Consumers and representatives were satisfied staff treat consumers with dignity and respect, and value them as individuals. Staff demonstrated familiarity with consumer backgrounds and spoke respectfully of and with consumers. Care planning documentation included information of consumers’ backgrounds and cultural needs.

Consumers, representatives, and staff explained how staff considered cultural preferences within care and services. Care planning documentation outlined cultural needs, and available information, including pamphlets and handbooks demonstrated value placed on consumers’ culture.

Consumers said they were supported to exercise choice to make decisions about their care and maintain relationships of choice. Staff described how they supported consumers exercise choice and independence about care and services. Care planning documentation reflected consumer choices.

Staff described different ways information is provided to consumers, including adapting communication style for consumers with cognitive and sensory impairment or language needs. Consumers were satisfied information was communicated in a way they understand. Staff were observed providing clear information to consumers to support decision making.

Some consumers said staff practice in demonstrating respect for privacy was inconsistent and had concerns personal information was indiscreetly discussed in communal areas. This was not reflected within observations or staff feedback, with staff outlining practical measures taken to respect consumer privacy and keep consumer information confidential. In response to consumer concerns, management sent reminders of expectations to all staff. Staff are guided by policies and procedures on privacy and confidentiality and information management.

# 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. | Not 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

The Quality Standard is assessed as Non-compliant as one of the 5 specific Requirements has been assessed as Non-compliant.

**Requirement (3)(a)**

The Assessment Team found this Requirement Met, providing evidence of effective assessment and planning processes to identify risks and inform delivery of safe and effective care and services. Staff could describe assessments undertaken within admission procedures and thereafter, in line with policies and procedures. Care planning documentation identified risks relating to personal and clinical care, and directives for safe management

However, evidence provided in Standard 1 Requirement (3)(d) relating to consumers who choose to take risks identified deficiencies in assessment and planning processes. The Assessment Team found the service did not undertake risk assessments and develop mitigating strategies for consumers choosing to leave the service independently, or consumers with a history of alcohol dependence who consumed alcohol outside the premises. Not all consumers who continued to drive had associated safety assessments.

Whilst the service has established processes for consumers who do not return to the service, these were not documented, and there was no evidence demonstrating these strategies had been discussed with or agreed to by consumers. Responsive actions from the provider focus on improvement to assessment of risks, including undertaking consultation and assessment of risks for consumers who choose to leave the service independently and/or consume alcohol. Within the formal risk assessment form are prompts to capture discussion and document agreed actions to minimise risks. Based on the evidence before me, considered within this Requirement and Standard 1 Requirement (3)(d), I find the service did not demonstrate assessment and planning identified risks and informed delivery of safe and effective care, and the service is Non-compliant with Standard 2 Requirement (3)(a).

**In relation to all other Requirements**

Consumers and representatives were satisfied assessment and planning identifies and addresses current preferences of consumers and captures end of life wishes. Staff described how assessment and planning was used to identify and reflect consumer preferences, and how they approach conversations about end-of-life care and were familiar with likes and dislikes of individuals. Care planning documentation identifies consumer needs, including dietary and lifestyle preferences.

Care planning documentation demonstrated assessment and planning involvement of consumers, representatives, and other providers of care. Staff described how they partner with consumers and representatives through assessment and care planning processes and engage other providers to meet consumer needs. Policies and procedures incorporate consultation and referral processes for assessment and planning.

Consumers and representatives said staff explain assessment and planning in a simple manner, clarifying personal and clinical matters if required. Most consumers said they have access to a copy of the care plan, with management providing progress notes for consumers who were uncertain to demonstrate each consumer had been offered the document but may have forgotten, and another copy was promptly arranged. Staff described how they communicate outcomes of assessment and planning with consumers and representatives in line with preferences. Summary and extended care plans were readily available within the electronic care management system.

Care planning documentation demonstrated care and services were reviewed regularly and following change of circumstances, including incidents. Staff described review processes including regular 3-monthly reviews, 2-monthly Resident of the day processes, identifying needs for change that are informed to consumers and representatives. Policies and procedures are available to guide staff in routine review of care planning documentation and following incidents.

# 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. | 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

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements have been assessed as Compliant.

Consumers and representatives were satisfied consumers received tailored, safe, and effective personal and clinical care. Staff were guided in delivery of care that was best practice, safe, and effective through documented processes. Care planning documentation demonstrated how care was personalised to optimise consumer health and well-being in relation to sampled areas of personal care, skin integrity and wounds, and pain management. The service cohort has a high incidence of mental health disorders, and the Assessment Team found indications for use of psychotropic medications were unclear for some consumers, however, each consumer had informed consent, assessments, detailed behaviour support plans, and monitoring of use. Furthermore, the service could demonstrate use of non-pharmacological strategies prior to use of psychotropic medication.

Staff were familiar with high impact and/or high prevalence risks for consumers and were able to describe mitigating strategies for individuals in line with care planning documentation. Consumers and representatives expressed satisfaction with management of consumer risks. Care planning documentation demonstrated risk management strategies were personalised to consumer needs and preferences. Clinical incidents are reported, reviewed, and trended to identify emerging and managed risks to consumers.

Staff described end of life care priorities, highlighting pain and comfort management and emotional support for family. Care planning documentation for a late consumer demonstrated provision of care in line with the consumer’s needs, goals, and preferences, focusing on monitoring and management of comfort and dignity. The service’s End of life care policy guides staff in provision of appropriate and culturally safe palliative care.

Consumers and representatives said consumer health changes were recognised, and appropriately responded to. Staff described processes to identify changes or deterioration to consumer health, with corresponding communication, monitoring, escalation for review, and documentation, including assessment and care planning needs. Care planning documentation demonstrated identification and timely response to deterioration or change in condition.

Consumers and representatives said staff work together to meet consumer care needs and preferences, and information does not need to be repeated to different staff. Staff described how information is shared through handover processes, progress notes, and care planning documentation. Care planning documentation demonstrated visiting providers, such as Medical officers and Allied health professionals, have access to consumer files.

Care planning documentation and progress notes demonstrated timely and appropriate referrals were made, in line with consumer feedback. Staff described how referrals were made to other organisations and providers of care to optimise quality outcomes for consumers. The service’s policies outlined referral requirements for management of clinical care, such as for falls, wound care, weight loss, changed behaviours, and pain.

Documentation is available to guide staff in infection control procedures, including outbreak management, and antimicrobial stewardship. Consumers identified observing staff actions to prevent and manage infection, including hand hygiene and cleaning processes. Staff explained actions to prevent and control infection, and steps to minimise the need for antibiotics. The service has 3 Infection prevention control leads, who are responsible for monitoring of practices and oversight of outbreaks. Visitors and staff were observed adhering to screening processes and use of personal protective equipment.

# 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 assessed as Compliant.

Care planning documentation captured consumer needs and preferences and required supports. Staff described engaging with consumers to understand needs and preferences and identify what consumers want to continue to do.

Consumers described how the service promotes their emotional, spiritual, and psychological well-being, with support available when they feel low. Care planning documentation includes actions to support and promote consumer emotional well-being. Staff advised they recognise when consumers feel low, and can provide emotional support, extra time, encouragement to undertake favoured activities, or engage pastoral care staff.

Consumers and representatives said consumers are supported to participate in communities within and outside the service, maintain relationships, and do things of importance. Staff demonstrated familiarity with consumer preferences in alignment with care planning documentation and described building rapport with consumers to better understand and cater for interests. The lifestyle calendar included activities within the community and to foster relationships between consumers and were noted to be well attended.

Staff described how information about consumers is shared within the organisation, including sharing dietary needs with kitchen staff, and with others involved in consumer care. Consumers and representatives were satisfied information was communicated with staff and others where responsibility for care is shared. Care planning documentation included sufficient information on services and supports to inform safe and effective care.

Care planning documentation demonstrated appropriate and timely referral to other organisations and services, such as volunteers and religious officers, in line with staff feedback.

Most consumers were satisfied with the quality and quantity of meals, with suitable alternatives available to meet preferences and dietary needs. Some consumers were not confident the meals were suitable for consumers with diabetes, however, management and kitchen staff explained the menu is reviewed and approved by a Dietitian and reduced sugar options are available to consumers. Staff described how consumer feedback is used to develop the menu, including from food focus groups.

Consumers reported having access to clean and suitable lifestyle equipment and mobility aids. Staff described having sufficient access to equipment, with effective cleaning and maintenance processes.

# 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

This Quality Standard is assessed as Compliant as 3 of the 3 Requirements have been assessed as Compliant.

Consumers and representatives described the service environment as welcoming, home-like, and easy to understand and navigate. Staff described aspects of the service to welcome and optimise consumer belonging, including encouraging personalisation of rooms. Shared spaces available to consumers included dining areas, library, gardens, courtyards, outdoor smoking areas, a chapel, and a recreation room, with navigational signage to guide consumers and visitors.

Most consumers were satisfied with the environmental cleanliness, and freedom of movement through indoor and outdoor areas. A strong smell of cigarettes was observed, and whilst most consumers said they were not negatively impacted, some reported dissatisfaction. Management reported high numbers of consumers choosing to smoke, with regular reminders of designated areas provided, and they will work with dissatisfied consumers to find a resolution. Staff described cleaning schedules, with quality monitoring undertaken through audits. Maintenance processes included service safety inspections and reactive processes. Consumers were observed moving throughout the service, using elevators to access other floors, and able to freely access indoor and outdoor areas.

Consumers said they have access to safe, clean, and well-maintained equipment. Staff said they had sufficient access to safe, clean, and well-maintained equipment, with cleaning processes after use for shared equipment and appropriate maintenance activities such as servicing and repairs.

# 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 assessed as Compliant.

Consumers and representatives said they felt safe and empowered to raise complaints and concerns and were familiar with feedback channels. Management and staff explained processes to encourage and support consumers to provide feedback or complaints. The service has two complaint officers to work with consumers about feedback in line with documented policies. Information was displayed on complaints processes and feedback forms observed to be readily available.

Management and staff described how the service informs consumers about available external complaints, advocacy, and language services. Consumers were familiar with available services, with information displayed including contact details. Management arranged visits from an external advocacy service to speak with consumers in June 2023.

Consumers and representatives were satisfied the service takes appropriate action to address complaints and concerns. Staff and management demonstrated understanding and application of an open disclosure process in response to complaints and when things go wrong. Documented complaints and incident reports included evidence of actions and use of open disclosure.

The service’s policies outlined a commitment to using feedback and complaints to improve care and services. Consumers and representatives expressed satisfaction with complaints processes and responsive improvements. Management described using feedback and complaints processes to identify trends to find improvements. Activities within the continuous improvement plan came from consumer feedback and other sources.

# 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. | Not 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 Non-compliant as one of the 5 specific Requirements has been assessed as Non-compliant. The Assessment Team recommended requirement (3)(d) and (3)(e) in this Standard Not Met.

**Requirement (3)(d)**

The Assessment Team were not satisfied there was a system in place to ensure staff are trained and equipped to deliver the outcomes required by the Quality Standards. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* One consumer said new staff required more training on medication administration.
* Some staff were unable to demonstrate applied knowledge restrictive practices.
* The service did not have processes to ensure staff completed mandatory training, resulting in low completion rates, although management advised the online education system included records of personnel not required to participate.
* Management was unable to clarify what mandatory training requirements for staff were.
* Training records were not accurate.

The provider’s response states they recognise improvements to be made monitoring and recording of education completed by staff, and has submitted the following information, evidence, and intended improvement actions in relation to deficits identified by the Assessment Team:

* New staff are not assessed for medication competency for at least 12 weeks, due to complexities of the consumer cohort. It is acknowledged this may cause frustration for some consumers to wait for requested medications.
* Formal training on the use of restrictive practice was completed in 2021 and has been scheduled for December 2023.
* Some of the modules reviewed by the Assessment Team are ‘preferred’ training rather than mandatory paid training. Staff are encouraged to do training at work in paid time but are not reimbursed if done in own time.
* Whilst the current system sends reminders for mandatory training, run regularly, not all staff check emails regularly, so a printed copy will be physically passed on during handover periods.
* It has been identified gaps in records of staff training. Continuous improvement activities have been created to bring all training records together into one document for effective oversight.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response. I acknowledge the provider’s position to determine timeframes for training, such as for the medication competency assessment. I also consider the evidence before me demonstrates the service has processes to identify training to meet the needs of the workforce. However, I place weight on management being unable to clarify what constituted mandatory training for the workforce, and not having sufficient oversight to ensure staff completed education required of them.

Whilst the service has identified improvements in record keeping to consolidate this information, and measures to follow up with staff overdue training, documentation from the provider reflects the only mandatory training for staff is relates to manual handling, Code of Conduct training, and fire and safety. The provider states other training modules are ‘preferred’ training, including hand hygiene and use of personal protective equipment, despite best practice requirements through the pandemic, and training records from the provider demonstrate many staff last undertook this training over 3 years ago. I also note the providers training records relating to the Quality Standards and legislative requirements identify training is not mandatory, including training on Serious Incident Response Scheme (SIRS) and incident management, and training on restrictive practice last completed in 2021 despite 6 of 16 Registered Nurses commencing employment since this date and changes to related legislation in December 2022.

I find the deficiencies relate to more than record keeping and oversight, and the service has not demonstrated the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. Based on the evidence in front of me, I find the service Non-compliant with Standard(3)(d)

**Requirement (3)(e)**

The Assessment Team were not satisfied there was an effective monitoring process to ensure assessment, monitoring and review of staff performance is undertaken. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Monitoring of staff performance appraisals was not sufficient, resulting in low completion rate and overdue reviews. Records prior to 2023 were unable to be provided.
* Management advised all performance appraisals are held in September and October, however, when asked about records completed from March to June 2023, management initially advised these were probationary reviews for new staff, however, later advised identified staff had elected to undertake review outside designated period.

The provider has neither accepted nor rejected the Assessment Team’s findings within their response, however, they include the following information and/or evidence:

* Bi-annual performance appraisals commence in September and are completed by November each year, with alternating years of online versus face-to-face reviews.
* Some staff had early review due to planned leave, and some will be done late due to leave or rostering have appointments to complete by 13 November 2023.
* New staff receive performance appraisals 6 weeks, 3 months, and 5 months after commencement, however, this is not recorded in the annual performance appraisal as the format is different
* All appraisals had been booked within the online system to be undertaken, with staff sent reminders 14 days before due, and reminder if over 24 hours late.

In coming to my finding, I have considered the Assessment Team’s findings and information within the providers response, including the continuous action plan activities. The provider has explained the difference between the formal review processes for new staff and established staff, with biennial appraisals for due staff booked to be undertaken by end of September. Additional appointments made for staff who are not available during this time due to leave or scheduling. The Assessment Team’s report includes formal monitoring processes for staff performance, including performance appraisals, and informal processes. I note records of 2022 staff performance reviews were not available to the Assessment Team without any explanation and would encourage the provider to ensure records demonstrate compliance with their own procedures. Based on the evidence before me, demonstrating the service has procedures, formal and informal review processes, and the provider uses a scheduled period for performance appraisals of all staff, I find the service compliant with Requirement (3)(e).

**In relation to all other Requirements**

All consumers and representatives expressed satisfaction with the number of staff and delivery of care. Management described processes to ensure there are enough staff to provide care through understanding consumer needs, using calculated care minutes as only one of several measures. Staff said they had enough time to complete their work without rushing. Rosters demonstrated coverage of unplanned absences through established processes, including negotiating with agencies for staff to ensure continuity of care.

Consumers and representatives said staff are kind, caring, and respectful, with staff demonstrating familiarity and understanding of consumer identities and needs. The service has policies, procedures, and training processes to ensure staff understand expectations.

Consumers and representatives said they consider staff to be skilled and competent. Management detailed processes to recruit staff with qualifications and knowledge to effectively perform their roles, seeking staff with experience relevant to the needs of the consumer cohort. Position descriptions detailed required qualifications, competencies, and responsibilities of each role.

# 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. | Not 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 Quality Standard is assessed as Non-compliant as one of the 5 specific Requirements has been assessed as Non-compliant. The Assessment Team recommended requirement (3)(c) in this Standard not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied the organisation wide governance systems were effective in relation to regulatory compliance. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The service has conflicting policies relating to requirement for police or NDIS check.
* Management referred to a Code of Conduct Policy, which referenced requirement for police check or ‘working with children’ check, however, this differs to the Police Check policy stating all staff must undergo a police record check every 3 years.
* The service did not have a system in place to follow up staff with an expired police check, resulting in nearly 15% of staff not having a current police or NDIS check at time of the Site Audit, despite the Police Check policy stating staff not holding this clearance would not be permitted to attend their shifts.
* The service did not identify all consumers prescribed psychotropic medications had corresponding diagnoses or indicators for administration for changed behaviours.

The provider has neither accepted nor rejected the Assessment Team’s findings within their response, however, they include the following information and/or evidence:

* A review of documentation reflected the ‘staff list’ included the Board and consultants, who do not require police checks as they do not spend time with consumers.
* Once excluded, 3 staff remained, with one on leave and two awaiting new NDIS checks. Online police checks have been undertaken in the interim. An intended completion date for this is 4 November 2023.
* New processes will be undertaken to ensure this information is captured for new employees, along with arranging NDIS checks due to consumer cohort.
* Monitoring will be undertaken within the monthly Residential Services Manager report, with due dates highlighted a month in advance to allow time to obtain and record clearances.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response, including continuous improvement actions. The provider has submitted evidence of actions being undertaken, including obtaining online police checks for staff and demonstrating most staff have either police or NDIS checks. However, one staff member identified as ‘pending’ clearance, in records submitted 6 October 2023 commenced employment in July 2023 and one clinical staff member’s police check expired in April 2023. Whilst 2 volunteers were included in summarised record of police checks, there were no records for Allied health or pastoral care staff.

The *Accountability Principles 2014* outlines responsibilities of providers to ensure all staff and volunteers has been issued with a police certificate within the past 3 years or made defined statutory declaration. The Department of Health’s Aged Care Worker Screening Guidelines (July 2021) provides further guidance with consideration to the *National Disability Insurance Scheme Act 2013* (NDIS Act) and Worker Screening Rules. The Worker Screening Rules define risk assessed roles, that is, those needing clearances, as being ‘key personnel roles as defined in s11A of the NDIS Act (for example, a CEO or a Board member’, as well as workforce involved in delivery of supports and services.

The provider’s response states they do not consider that Board members and consultants require police checks, however, this is not in alignment with legislative requirements referenced above. In coming to my decision, I have also placed weight on the conflicting guidance material within policies, with the Code of Conduct policy referencing the service’s acceptance of a working with children check instead of police or NDIS checks, which does not meet legislative requirements. I consider the incongruency of policies to further reflect deficiencies in governance systems and oversight processes.

I have insufficient evidence to demonstrate the Assessment Team findings relating to identifying indications for use of psychotropic medications arise from poor governance processes. However, I have placed weight on the finding of Non-compliance in Standard 7 Requirement (3)(d) relating to deficiencies in oversight processes to ensure staff have access to and complete necessary training to understand legislative requirements and deliver outcomes required by the Quality Standards.

Based on the evidence before me, I find Requirement (3)(c) of Standard 8 Organisational governance Non-compliant.

**In relation to all other Requirements**

Consumers and representatives described the service as well run and expressed satisfaction with their level of engagement in the service’s delivery of care and services. Management described engagement and consultation processes with consumers, including through the decision for the service to merge with another organisation in 2024. Continuous improvement activities demonstrate progress in developing a consumer advisory body by 1 December 2023 to be carried through the merger process to the new organisation.

Management described the organisational structure that governs the delivery of care, consisting of a Board and focused subcommittees. Management explained how the Board maintained oversight through reporting processes and improvement activities, giving examples of actions the Board had taken to ensure the service provided safe, inclusive, and quality care and services. Documentation, including meeting minutes, demonstrated the Board is informed of all relevant service information and drives responsive actions.

Staff demonstrated awareness of processes and responsibilities for reporting incidents, including through SIRS. Management was able to describe high impact and/or high prevalence risks for the consumer cohort, with oversight through monitoring and management strategies, including ensuring access to appropriately skilled staff. The service has policies to guide staff through risk management, elder abuse and neglect, and reporting processes.

Staff could demonstrate how clinical governance frameworks were applied in the delivery of care and services, through following policies and guidelines. Oversight of clinical care was undertaken by management and within clinical meetings, including the Medication advisory committee. Reporting processes for use of antimicrobial medication or chemical restraint provided guidance through prompts and triggered monitoring processes.

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)