Performance

Report

**1800 951 822**

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| Name of service: | Corumbene Hostel |
| Service address: | 13-23 Lower Road NEW NORFOLK TAS 7140 |
| Commission ID: | 8024 |
| Approved provider: | Corumbene Nursing Home for the Aged Inc |
| Activity type: | Site Audit |
| Activity date: | 12 April 2023 to 14 April 2023 |
| Performance report date: | 16 June 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 Corumbene Hostel (**the service**) has been prepared by J Howard, 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 conducted from 12 April 2023 to 14 April 2023. 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 Approved Provider’s response to the site audit report, received 18 May 2023.
* Other information and intelligence held by the Aged Care Quality and Safety Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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)(e)* – The Approved Provider must ensure care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact the needs, goals or preferences of the consumer.
* *Requirement 3(3)(b)* – The Approved Provider must ensure the effective management of high-impact or high-prevalence risks associated with the care of each consumer.
* *Requirement 4(3)(d)* – The Approved Provider must ensure information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.
* *Requirement 6(3)(d)* – The Approved Provider must ensure feedback and complaints are reviewed and used to improve the quality of care and services.
* *Requirement 7(3)(d)* – The Approved Provider must ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* *Requirement 7(3)(e)* – The Approved Provider must ensure the regular assessment, monitoring and review of the performance of each member of the workforce.
* *Requirement 8(3)(c)* – The Approved Provider must ensure it has effective organisation wide governance systems relating to: continuous improvement; workforce governance, including the assignment of clear responsibilities and accountabilities; and regulatory compliance.
* *Requirement 8(3)(d)* – The Approved Provider must ensure it has effective risk management systems and practices relating to managing high-impact or high-prevalence risks associated with the care of consumers.
* *Requirement 8(3)(e)* – The Approved Provider must ensure that where clinical care is provided, its clinical governance framework minimises the use of restraint.

# Standard 1

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| Consumer dignity and choice | | Compliant |
| 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

The Quality Standard is assessed as Compliant, as six of the six specific requirements were assessed as Compliant.

Consumers said staff treated them with dignity and respect, which the Assessment Team observed. Consumers’ care plans included information about their background, culture and preferences. Consumers confirmed staff were respectful of their cultures, beliefs and values, which was evident in the number of opportunities for consumers to practice their religious beliefs. Consumers were supported to make choices about their care and who should be involved in their care. Consumers maintained their relationships of choice and had personal phones they used to contact family.

Consumers were supported to take risks which enabled them to live life in a fulfilling way. For consumers wishing to take risks, a risk assessment and dignity of risk form was completed and documented in their care plans. Consumers confirmed they were provided with information that was current, accurate, timely and enabled them to exercise choice about their care. For example, information was disseminated via direct discussions with staff, an activity schedule, pamphlets and bulletin boards displayed throughout the service. Consumers confirmed care and services were delivered in a way which respected their privacy. The Assessment Team noted the nurse’s station was closed at all times and staff knocked on consumers’ doors before entering.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| 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. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 2(3)(e).

*Requirement 2(3)(e):*

The Assessment Team considered the service did not regularly review care and services for effectiveness when consumers’ circumstances changed, or when incidents impacted on their needs, goals or preferences.

For example, following multiple falls, some consumers’ care plans were not updated and therefore, information about their needs and conditions were inaccurate and outdated. Management advised the Assessment Team they were aware consumers’ care and services were not always reviewed for effectiveness. Notwithstanding, the Assessment Team noted clinical and care staff understood consumers’ current needs, despite the information not being available in care plans.

In its response of 18 May 2023, the Approved Provider presented a plan for continuous improvement (PCI) concerning the regular review of consumers’ needs when their circumstances changed or when incidents occurred. The PCI included details of remedial actions being taken and advised they would be completed by August 2023.

Actions included:

* Conduct an audit to determine which consumers’ care plans require a review and update those identified.
* Ensure interventions are evaluated for effectiveness.
* Conduct a review of multiple policies which address the assessment of consumers’ needs and recording the outcome in care plans.
* Provide staff with education on completing assessments and care plans.
* Monitor completion of assessments and care plans.
* Provide newsletter to consumers and representatives which addresses care planning.
* Care manager to monitor ongoing compliance, regularly reviewing consumers’ care and services, particularly following a return from hospital.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies identified in the site audit report, at the time of the site audit, management acknowledged consumers’ care and services were not reviewed regularly for effectiveness. The service is still implementing its remedial actions and it anticipates its actions will be fully implemented and effective by August 2023. Therefore, I find the service was non-compliant with Requirement 2(3)(e) at the time of the Site Audit.

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 2.

Consumers confirmed they were involved in the assessment and care planning process, which included identifying risks to consumers. A review of care plans confirmed risks were identified and consumers were satisfied with risk management as it applied to them. The service included end-of-life planning in the assessment process, and this was confirmed by consumers, representatives and a review of care plans. The service partnered with consumers, their representatives, medical and allied health professionals when assessing, planning and reviewing care needs.

Consumers gave mixed feedback about whether the outcomes of assessment and planning were communicated to them by way of being offered a copy of their care plan. Management advised all consumers had copies of their care plans in their wardrobes; however, not all consumers were aware of this. The Assessment Team noted copies of care plans were available in consumers’ wardrobes.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Non-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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 3(3)(b).

*Requirement 3(3)(b):*

The service managed some high-impact and high-prevalence risks to consumers, such as low mood and poor appetite. However, the Assessment Team noted that where some consumers had falls, care documentation was incomplete or inconsistently completed.

For example, incident forms did not always include corrective actions to be taken and consumers’ falls risk assessments and prevention strategies were not updated following a fall. In addition, some consumers’ care documentation incorrectly stated they had not experienced a fall in the preceding year, despite having had repeated falls.

In its response of 18 May 2023, the Approved Provider presented a PCI regarding the effective management of high-impact or high-prevalence risks associated with the care of each consumer. The PCI included details of remedial actions being taken and advised they would be completed by July 2023.

Actions included:

* Review processes for the identification and management of high-impact risks.
* Develop a clinical risk register.
* Provide staff with education in risk management.
* Review consumers’ care plans to ensure risks are identified and management or mitigation strategies are in place.
* Consumers with identified risks to be reviewed fortnightly by the senior clinical team.
* Develop a high-impact, high-prevalence risk policy and procedure.
* Implement a falls prevention and management policy and procedure (this was done on 15 May 2023).
* Conduct an audit of consumer falls and subsequent review by a physiotherapist (this was completed in May 2023).
* Monitor falls data to mid-August 2023, to ensure all assessments, documentation and follow-up actions are completed correctly.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the Site Audit the service was not effectively managing high-impact or high-prevalence risks associated with the care of each consumer. The service is still implementing its remedial actions and it anticipates its responses will be implemented and effective by July 2023. Therefore, I find the service was non-compliant with Requirement 3(3)(b) at the time of the Site Audit.

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 3.

Consumers confirmed they received personal and clinical care tailored to their needs. Consumers confirmed the service acknowledged advanced care planning and their end-of-life preferences with them, which were recorded in care plans. Staff who provided palliative care described how care delivery changed during the end-of-life process, such as ensuring consumers were comfortable with their dignity preserved through pain management and ensuring spiritual needs were met.

Consumers confirmed changes in their conditions were recognised and responded to in a timely manner. Changes to consumers’ conditions were communicated within the organisation via shift handovers, at weekly staff meetings and by email. Consumers confirmed referrals to other providers of care and services were timely, and this was consistent with referral documentation. The service had processes in place to minimise infection-related risks and support the appropriate prescribing of antibiotics.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non-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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 4(3)(d).

*Requirement 4(3)(d):*

The Assessment Team considered information about consumers’ dietary needs and preferences was not well communicated within the organisation. Though management stated consumers’ dietary requirements and preferences were documented in their care plans, some staff advised there is insufficient time to read the information prior to serving meals. Subsequently, kitchen staff relied on care and nursing staff, the consumer or consumer representative to advise them of individuals’ dietary requirements. Kitchen staff confirmed consumers and care staff advised them of consumers’ dietary requirements, which were recorded on the ‘dietary whiteboard’ and ‘other documentation’ in the kitchen.

The Assessment Team observed one consumer being served food which, if eaten, could cause negative health outcomes. Further, a review of the consumer’s care plan showed the absence of a risk assessment and dignity of risk form, should the consumer wish to continue eating foods which could cause them harm. Another consumer advised the Assessment Team they were allergic to a food which could result in their hospitalisation. However, staff had been serving the food to the consumer since October 2020, despite the consumers’ food allergy being recorded in their care plan and in the kitchen’s documentation. The Assessment Team did not receive a response from management regarding this issue.

In its response of 18 May 2023, the Approved Provider presented a PCI regarding how information about consumers’ dietary needs and preferences is communicated within the organisation. The PCI included details of remedial actions being taken and advised they would be completed by August 2023.

Actions included:

* Conduct an audit to ensure consumers’ dietary needs, allergies and preferences aligned with information given to kitchen staff.
* Review the menu planning process to identify gaps, ensure consumers are involved and consider providing alternate food choices at mealtimes.
* Provide care staff with education in modified and texturised diets.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the Site Audit the service was not effectively communicating information about consumers’ condition, needs and preferences as they related to food intolerances and allergies. The service is still implementing its remedial actions and it anticipates its actions will be complete and effective by August 2023. Therefore, I find the service was non-compliant with Requirement 4(3)(d) at the time of the Site Audit.

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 4.

Consumers received services that optimised their well-being and quality of life. Staff described how they supported consumers to maintain their independence and do things of importance to them. For example, consumers were observed enjoying a variety of activities during the site audit, along with interacting with each other, staff and visitors to the service. The lifestyle coordinator advised the service’s activities schedule is flexible, can be changed to suit consumers’ needs and was evaluated bi-annually. Consumers confirmed they received the emotional, spiritual and religious supports needed to maintain their psychological well-being.

Consumers participated in their community, did things of interest to them and were supported to maintain personal relationships. For example, consumers went on regular bus outings, while others were supported to maintain telephone contact with family and arrange visits to the service. With respect to meals at the service, consumers were generally satisfied with the quality, quantity and variety of food provided. Consumers could access alternative meal options if the menu was not to their liking. Where the service provided equipment, consumers said it was safe, clean and well maintained, and this was supported by the Assessment Team’s observations.

# Standard 5

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| Organisation’s service environment | | Compliant |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Quality Standard is assessed as Compliant, as three of the three specific requirements were assessed as Compliant.

The service environment was welcoming and promoted a sense of independence and belonging. onsumers felt at home within the service, particularly as they personalised their rooms with possessions of their choosing. The service environment was clean, well maintained and consumers moved freely within and outside of the building. The service had regular cleaning and maintenance schedules and maintenance logs, with licensed tradespeople used as needed.

The Assessment Team observed staff cleaning consumers’ rooms, hallways and common areas. Consumers confirmed furniture, fittings and equipment was clean, well maintained and suitable for their needs. A review of the service’s maintenance log confirmed unsafe equipment was promptly fixed.

# Standard 6

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| Feedback and complaints | | Non-compliant |
| 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. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 6(3)(d).

*Requirement 6(3)(d):*

The Assessment Team noted the service was not reviewing feedback and complaints to improve the quality of consumers’ care and services. A review of documentation showed the service ceased using a plan for continuous improvement (PCI) in mid-2022 and management was unable to provide evidence that complaints were regularly reviewed and used to improve care and services. A review of three complaints confirmed actions were taken in response to feedback, although there was no record of those actions being reviewed for effectiveness.

In its response of 18 May 2023, the Approved Provider presented a PCI regarding how feedback and complaints would be monitored, analysed, trended, reviewed for effectiveness and linked to the service’s PCI. The PCI included details of remedial actions being taken and advised they would be completed by August 2023.

Actions included:

* A review of the complaints management framework and implementation of a quality assurance system which will include workflows and an escalation process.
* Monthly complaints trend analysis provided to executive leadership teams and the board of directors.
* Open complaints are a standing meeting agenda item until resolved, with evidence the information is used for continuous improvement and informs staff education and performance management.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the Site Audit the service was not reviewing feedback and complaints to improve the quality of consumers’ care and services. The service is still implementing its remedial actions and it estimates its actions will be complete and effective by August 2023. Therefore, I find the service was non-compliant with Requirement 6(3)(d) at the time of the site audit.

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 6.

The service encouraged consumers and representatives to provide feedback and make complaints. Feedback and complaints could be submitted via resident and relative meetings, electronic mail, feedback forms, an annual survey and by speaking directly with staff and management.

Information about how to make an internal or external complaint, provide feedback and access advocacy and interpreter services was available in the consumer welcome pack and in brochures within the service. Management and staff understood the complaints management process and the importance of using open disclosure when something went wrong.

# Standard 7

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| Human resources | | Non-compliant |
| 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirements 7(3)(d) and 7(3)(e).

*Requirement 7(3)(d):*

Consumers were satisfied staff were adequately trained and equipped to perform their roles. A review of service documentation confirmed the workforce was appropriately recruited. However, the Assessment Team could not identify any evidence the service had systems to support staff to complete training which would equip them to deliver care in accordance with the Quality Standards. While the service had an annual mandatory training schedule, staff completion rates were below fifty percent.

In its response of 18 May 2023, the Approved Provider presented a PCI which set out proposed actions concerning how it will support staff to complete training to equip them to care for consumers in a way which meets the Quality Standards. The PCI included details of remedial actions being taken and advised they would be completed by September 2023.

Actions included:

* A review of staff education records to identify those who need to complete mandatory and supplementary education.
* Weekly reports of outstanding education to be completed by staff is sent to the executive team and managers.
* Human resources staff to follow-up outstanding education each fortnight.
* Implementing an internal internet hub for staff to complete education.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the Site Audit the service was not ensuring staff were trained to deliver care in accordance with the Quality Standards. The service is still implementing its remedial actions and it estimates its actions will be completed and effective by September 2023. Therefore, I find the service was non-compliant with Requirement 7(3)(d) at the time of the Site Audit.

*Requirement 7(3)(e):*

The service had a performance management policy and procedure which required regular assessment of staff performance. However, the Assessment Team’s review of records showed the service was not regularly assessing, monitoring and reviewing staff performance. Management advised it was aware annual staff appraisals had low levels of completion and stated it would address the issue promptly.

In its response of 18 May 2023, the Approved Provider presented a PCI regarding how it would ensure staff performance is regularly assessed, monitored and reviewed. The PCI included details of remedial actions being taken and advised they would be completed by September 2023.

Actions included:

* A review of the current staff appraisal process to identify gaps and staff members whose appraisal is overdue.
* Planned training on how to complete staff appraisals.
* Development of a simpler appraisal form.
* Human resources to send fortnightly notifications to staff until all appraisals are completed.
* Creation of a performance review schedule to ensure outstanding appraisals are completed by 30 June 2023.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the Site Audit the service was not ensuring staff were trained to deliver care in accordance with the Quality Standards. The service is still implementing its remedial actions and it estimates its actions will be completed and effective by September 2023. Therefore, I find the service was non-compliant with Requirement 7(3)(e) at the time of the Site Audit.

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 7.

Consumers were aware of staffing challenges at the service, but indicated their care had not been adversely affected. A review of the previous fortnight’s roster showed an adequate level of staff across three daily shifts. The roster system only allows for appropriately skilled staff to be selected for shifts. Consumers confirmed staff were kind, caring and respectful of their cultural backgrounds when providing care and services. Staff were observed addressing consumers by their preferred names and knocking on consumers’ doors prior to entering their rooms. The service’s workforce was competent and had the qualifications and knowledge to effectively perform their roles, which was reflected in positive consumer feedback.

# Standard 8

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| Organisational governance | | Non-compliant |
| 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. | Non-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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirements 8(3)(c), 8(3)(d) and 8(3)(e).

*Requirement 8(3)(c):*

The service had effective governance systems that guided information management, financial governance and feedback and complaints.

However, the Assessment Team could not find evidence the service had effective governance systems to support continuous improvement, workforce governance and regulatory compliance.

In relation to continuous improvement, management said the service had a system whereby it pursued, identified, monitored and reviewed opportunities for improvement. However, management were unable to provide evidence of the service’s continuous improvement system.

The Assessment Team reviewed the service’s plan for continuous improvement (PCI) for 2022, as there was not a PCI in place for 2023. The PCI for 2022 had many action and outcome items left blank. Management advised the service was in the early stages of transition to a new ‘electronic system’ and acknowledged the current system had not been effectively managed in the interim.

In relation to workforce governance, the service was not effectively monitoring completion rates of mandatory staff training and annual performance reviews. There was no evidence the service had systems to support staff to complete training which would equip them to deliver care in accordance with the Quality Standards. Whilst the service had an annual mandatory training schedule, staff completion rates were below fifty percent.

In relation to regulatory compliance, the Assessment Team found seven of 114 staff did not have current national police checks.

In relation to restrictive practices, the service’s restraint management policy and procedure was outdated and nine of eleven (91%) of sampled consumer files did not have signed consent forms where the person was subject to a restrictive practice.

In its response of 18 May 2023, the Approved Provider presented a PCI regarding how its governance systems were being reviewed to effectively support continuous improvement, workforce management and regulatory compliance. The PCI included details of remedial actions being taken and advised they would be completed between June 2023 and September 2023.

Actions included:

* A review of the quality framework and audit schedule to identify gaps and ensure these are linked to the service’s PCI.
* The PCI is a standing agenda item at all relevant meetings.
* Implementation of a quality assurance system provided automated links to the PCI register.
* Three of seven staff with outdated national police checks at the time of the Site Audit have provided a current check, with a further three having resigned prior to the audit and one is on long-term leave.
* A review of staff education records to identify those who need to complete mandatory and supplementary education.
* Implementing an internal internet hub for staff to complete education.
* Creation of a performance review assessment schedule to ensure outstanding staff appraisals are completed by 30 June 2023.

The Approved Provider’s response did not address how it would ensure the required assessments and consents were in place for consumers subject to a restrictive practice.

While I acknowledge the Approved Provider is now taking steps to remedy most of the deficiencies under Requirement 8(3)(c), at the time of the Site Audit the service did not have effective governance systems to support continuous improvement, workforce governance and regulatory compliance. The service is still implementing its remedial actions and it may take time for them to be fully effective, with the service estimating its actions would be completed by September 2023. Therefore, I find the service was non-compliant with Requirement 8(3)(c) at the time of the Site Audit.

*Requirement 8(3)(d):*

The service managed some high-impact and high-prevalence risks to consumers, such as low mood and poor appetite. However, the Assessment Team found that where some consumers had falls, care documentation was incomplete or inconsistently completed.

For example, incident forms did not always include corrective actions to be taken and consumers’ falls risk assessments and prevention strategies were not updated following a fall. In addition, some consumers’ care documentation incorrectly stated they had not experienced a fall in the preceding year, despite having had repeated falls.

In its response of 18 May 2023, the Approved Provider presented a PCI regarding the effective management of high-impact or high-prevalence risks associated with the care of each consumer. The PCI included details of remedial actions being taken and advised they would be completed by July 2023.

Actions included:

* Review processes for the identification and management of high-impact risks.
* Develop a clinical risk register.
* Provide staff with education in risk management.
* Review consumers’ care plans to ensure risks are identified and management or mitigation strategies are in place.
* Implement fortnightly reviews by the senior clinical team of consumers with identified risks.
* Develop a high-impact, high-prevalence risk policy and procedure.
* Implement a falls prevention and management policy and procedure (this was done on 15 May 2023).
* Conduct an audit of consumer falls and subsequent review by a physiotherapist (this was completed in May 2023).
* Monitor falls data to mid-August 2023, to ensure all assessments, documentation and follow-up actions are completed correctly.

While I acknowledge the Approved Provider is now taking steps to remedy the deficiencies, at the time of the Site Audit the service was not effectively managing high-impact or high-prevalence risks associated with the care of each consumer. The service is still implementing its remedial actions and it may take time for them to be fully effective, with the service estimating its actions would be implemented by July 2023. Therefore, I find the service was non-compliant with Requirement 8(3)(d) at the time of the Site Audit.

*Requirement 8(3)(e):*

The service had systems in place to promote antimicrobial stewardship and the use of open disclosure when something goes wrong.

However, there was no evidence the service had an effective clinical governance framework which ensured the required assessments and consents were in place for consumers subject to a restrictive practice.

The service’s restraint management policy and procedure was outdated and 91% of sampled consumer files did not have signed consent forms where the person was subject to a restrictive practice.

The Approved Provider’s response did not address how it would ensure the required assessments and consents were in place for consumers subject to a restrictive practice.

Therefore, I find the service was non-compliant with Requirement 8(3)(d) at the time of the Site Audit.

*The other Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 8.

Consumers and representatives were engaged in the development, delivery and evaluation of care and services. Input was provided via resident and relative forums, surveys and feedback given to staff. The organisation’s board of directors (the board) promoted a culture of safe, inclusive and quality care and services, for which it was accountable. The board maintained visibility of the service’s performance through sub-committees which focused on infection outbreak management, medication management, clinical governance and work, health and safety.

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