Performance

Report

**1800 951 822**

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| Name of service: | Elizabeth Lodge Hostel |
| Service address: | 79 Mt Pleasant Avenue Wahroonga NSW 2076 |
| Commission ID: | 0179 |
| Approved provider: | Seventh-day Adventist Aged Care (Greater Sydney) Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 August 2023 to 9 August 2023 |
| Performance report date: | 14 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 Elizabeth Lodge Hostel (the service) has been prepared by G Jones, 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.
* the provider’s response to the assessment team’s report received 6 September 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-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)**

Ensure care and services documentation consistently shows review of the effectiveness of care and services when a consumer’s circumstances change or an incident occurs impacting their needs, goals and preferences.

**Requirement 3(3)(a)**

Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: is best practice; and is tailored to their needs; and optimises their health and well-being in relation to:

1. behaviour support plans contain individually tailored strategies and include all the required information per the *Quality of Care Principles 2014* (Cth);
2. restrictive practices are used as a last resort
3. clinical monitoring following falls is completed as per organisational guidelines to maintain the consumer’s health and safety.

**Requirement 6(3)(d)**

Ensure feedback and complaints are reviewed, which includes trending and analysis of feedback and complaints received, and used to improve the quality of care and services.

Ensure consumer involvement in finding solutions to feedback and complaints raised to improve quality care and services.

**Requirement 7(3)(d)**

Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

**Requirement 7(3)(e)**

Ensure regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

**Requirement 8(3)(c)**

Ensure 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; and
6. feedback and complaints.

**Requirement 8(3)(d)**

Ensure 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 and
4. managing and preventing incidents, including the use of an incident management system.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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

Requirement 2(3)(b)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were assessment and care planning did not adequately address all areas of care and services or individual preferences and needs, including advance care and end of life planning. Some documented needs and goals were of a generic nature. There was a gap in pain assessment and management for one consumer, and lack of documented advanced care or end of life directives.

Since that time the service has undertaken improvement activities including delivering staff training on palliative care and pain management and conducting audit activity.

The actions taken in response to the non-compliance have been effective.

The Assessment Team found that assessment and planning is occurring for consumers in relation to advance care and end of life care, however, a review of care documentation, including care and services plans, did not always show current needs, goals and preferences of the consumers. For example, a care plan for one consumer stated ‘likes hymns’ and ‘involve in meaningful activities’ but did not outline what meaningful activities are for this consumer or what kind of hymns the consumer enjoyed to guide staff practices. Another care plan referred to ‘if the consumer wears glasses’ which suggests that the care plan is generic in nature and not individualised to the consumer. Furthermore, behaviour support plans did not have all required information per the Quality of Care Principles 2014 (Cth).

The Approved Provider provided a response to the Assessment Team’s report and supplied further information and clarification in relation to this requirement. The Approved Provider stated that information about consumer’s needs, goals and preferences is recorded in multiple assessments and this information combines to guide staff practices. Evidence was provided to demonstrate this. The Approved Provider also supplied information showing that they had updated assessment information based on feedback from the Assessment Team.

I have decided to consider the issue of behaviour support plans not having all required information per the Quality of Care Principles 2014 (Cth) in Requirement 3(3)(a).

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(b) is Compliant.

Requirement 2(3)(c)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that while the service had processes in place to ensure assessment and planning were based on an ongoing partnership with consumers and others, this was not occurring. Representative feedback included not being involved in discussions and/or informed of risks related to prescribed medications. Consumers experiencing unplanned weight loss were not consistently referred to a dietitian, physiotherapy review did not occur when a consumer experienced a fall, and specialist review did not consistently occur in relation to wound care.

Since that time the service has undertaken improvement activities including providing staff education, undertaking auditing activity to review case conferences held, and auditing of falls referrals followed up by physiotherapy assessment.

The actions taken in response to the non-compliance have been effective.

Consumers and their representatives interviewed provided examples of their involvement in assessment and care planning. Consumers spoke of being able to have ‘a say’ in their care planning. Evidence provided showed discussions on a broad range of care issues and concerns with both consumers and their representatives. Staff interviewed stated they are working with other practitioners and providers of care and services involved in the care of the consumer and care documentation demonstrated this.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team Requirement 2(3)(c) is Compliant.

Requirement 2(3)(d)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that feedback received from some consumers and representatives indicated they were not included in discussions to inform care planning, nor were they provided with a copy of care planning documentation. Documentation did not consistently demonstrate care plans were offered to consumers and/or their nominated representative.

Since that time the service has undertaken improvement activities including explaining the purpose of a care plan and providing care plans at case conferences to consumers and their representatives.

The actions taken in response to the non-compliance have been effective.

Consumers and their representatives interviewed stated that they were kept up to date with any changes that occurred and were able to get a copy of the care plan. Management explained how they communicate with consumers and their representatives and documentation reviewed supported that this occurs.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team Requirement 2(3)(d) is Compliant.

Requirement 2(3)(e)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that review of care was not consistently conducted when circumstances changed and/or incidents impact their needs. Skin and pain assessments were not consistently completed when consumers experienced pressure injury/wound deterioration, nor when a consumer experienced a fall.

Since that time the service has undertaken improvement activities including audit activity to review wound care documentation and pain assessment.

The actions taken in response to the non-compliance have been ineffective.

Whilst consumers and their representatives stated they generally felt they were kept up to date, care and service records did not consistently show review of the effectiveness of care and services when a consumer’s circumstances changed or an incident occurred impacting their needs, goals and preferences.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 2(3)(e) is Non-compliant.

# 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. | Non-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

Requirement 3(3)(a)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that appropriate care is not consistently provided in relation to wound care, pain management, unplanned weight loss, and falls management. Monitoring processes were not used to ensure fluid restrictions were adhered to, and documentation did not demonstrate informed consent for restrictive practices.

Since that time the service has undertaken improvement activities including auditing wound care and falls assessments, reviewing policies and procedures and providing education to staff on a range of clinical issues.

The actions taken in response to the non-compliance have been ineffective.

Whilst consumers and their representatives gave positive feedback about the care consumers receive at the service, the Assessment Team found it was not consistently demonstrated that consumer care is best practice, tailored to consumer needs or that it optimises their health and well-being.

The Assessment team found that, in relation to behaviour support, consumers did not always have a behaviour support plan in place that contained individually tailored strategies to optimise their health and well-being. Furthermore, behaviour support plans did not have all the required information per the Quality of Care Principles 2014 (Cth). Interventions such as lowering a consumer’s bed are not being considered as mechanical restraint and chemical restraint not being used as a last resort.

The clinical monitoring of two consumers following falls had not been completed by staff in line with organisational guidance material for staff to maintain the consumer’s health and safety.

Additionally, consumers did not have photographs on their profile in the electronic medication management system increasing the risk of medications being administered to the wrong consumer. I note these issues was addressed whilst the Assessment Team was on site.

The Approved Provider in their response to the Assessment team’s report, did not dispute the Assessment Teams findings in relation to these issues.

The Approved provider supplied further information and clarification in relation to the wound care provided to one consumer and the behaviour support plan pertaining to another consumer which was accepted.

Having considered the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is Non-compliant.

Requirement 3(3)(b)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that appropriate follow up was not evident for some consumers after experiencing a fall, wound management processes were not consistently implemented per directives, and appropriate referral for unplanned weight loss was not evident.

Since that time the service has undertaken improvement activities including staff training in falls documentation and management, wound management and timely referral to other health professionals.

During the Assessment contact consumers and representatives provided positive feedback about the care of consumers and how high impact, high prevalence risks are managed. The Assessment team found some high impact, high prevalence risks associated with the care of consumers are managed effectively, however information gathered did not show that the risk of skin injuries or malnutrition/unplanned weight loss were being managed effectively. Falls risk was being managed effectively except for one incident where the Assessment Team saw a consumer being pushing on her 4-wheel walker by a member of staff instead of transferring to an appropriate assisted mobility device.

In relation to skin tears, the number of consumers with skin tears has been increasing overall. Where skin tears had occurred, incident reports do not show thorough investigation to help identify how the skin tear occurred to prevent future injuries. In the consumers sampled by the Assessment Team, both consumers could not remember how the injuries had occurred and there was no documented evidence the service had further investigated how the injuries might have occurred. The Assessment team also identified wound deterioration in one consumer, noting the service was slow to refer to a wound care specialist when this occurred.

The Approved Provider provided a response to the Assessment Team’s report and supplied further information in relation to this requirement.

In relation to wound care I have accepted the additional information provided by the Approved Provider which demonstrated staff were trialling alternative solutions prior to referral to the wound care specialist. I have also considered that the wound is healing well.

In relation to skin tears, the Approved Provider argued that both consumers were ‘cognitively able’ and, therefore, their lack of explanation for their injuries should be accepted by staff. Whilst I understand the point being made by the Approved Provider, I would expect staff investigate what happened to identify possible causes, documenting same, particularly when the consumer does not remember how the skin tear occurred.

In relation to unplanned weight loss, I have considered the information provided by the Approved Provider and am satisfied that that unplanned weight loss is being appropriately managed.

Having considered both the information provided by the Assessment Team and the Approved Provider, I am satisfied Requirement 3(3)(b) is Compliant.

Requirement 3(3)(c)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that not all consumers/representatives had been consulted in relation to advance care planning. Staff noted they required palliative care training. Consumers did not consistently have appropriate end of life directives and not all consumers (deemed as requiring palliative care) had instructions to guide staff in providing care as per their needs and wishes.

Since that time the service has undertaken improvement activities including staff training in palliative care and updating the palliative care policy and procedures.

The actions taken in response to the non-compliance have been effective.

Consumer representatives provided positive feedback in relation to the care consumers received or are receiving during the end of life to ensure their comfort is maximised and dignity preserved. Management explained the care process that occurs to support consumers during end of life and review of consumer care and services records showed the process is being followed by the staff.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 3(3)(c) is Compliant.

Requirement 3(3)(d)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that the service did not consistently demonstrate changes/deterioration such as infection, wound deterioration and unplanned weight loss, is recognised or responded to in a timely manner.

Since that time the service has undertaken improvement activities including reviewed the process for responding to deterioration and completed staff training.

The actions taken in response to the non-compliance have been effective.

Consumer representatives provided positive feedback about the care consumers received including when deterioration was noted. The Assessment Team sampled consumers whose condition had deteriorated to understand actions taken by the service to support them and found that deterioration was recognised and responded to in a timely manner.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Based on the information provided by the Assessment Team, Requirement 3(3)(d) is Compliant.

Requirement 3(3)(e)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that systems for communicating consumer information were not consistently effective for all consumers. Unplanned weight loss was not consistently referred to a dietitian. Monitoring of BGLs was not consistently communicated to doctors per consumer directives and medication changes were not advised to clinical staff. Complex clinical care needs were not consistently recorded to guide staff in care provision, and a representative was not advised when a change to a consumer’s living environment occurred.

Since that time the service has undertaken improvement activities including staff training on timely communication with others, including referral for treatment, and documenting appropriate interactions.

The actions taken in response to the non-compliance have been effective.

Management and staff explained how information is communicated within the organisation and with others outside the organisation where care is shared. Consumer representatives stated they were communicated with regarding the condition, needs and preferences of consumers where responsibility for care is shared.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 3(3)(d) is Compliant.

Requirement 3(3)(f)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that appropriate referrals to relevant health professionals did not consistently occur. Consumers experiencing wound deterioration were not referred to a wound specialist or dietician in a timely manner. Psychogeriatric review recommended by a dementia specialist did not occur. Physiotherapy review post-fall did not occur in a timely manner for one consumer, and unplanned weight loss was not consistently referred for review.

Since that time the service has undertaken improvement activities including staff training on the referral process for specialists and allied health.

The actions taken in response to the non-compliance have been effective.

Management advised they work with many different providers of care and services to support meeting consumers’ care needs. Review of consumer care and service records shows the service’s staff work with a variety of other health and allied health providers including the service’s physiotherapist.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 3(3)(f) is Compliant.

Requirement 3(3)(g)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were that staff were not adhering to appropriate infection control practices, such as wearing of personal protective equipment (PPE). There was a lack of individual equipment for use when assisting consumers to mobilise and a lack of evidence that shared equipment was being adequately cleaned between consumers. Also, staff were not ensuring adequate hydration as a method of infection prevention for one consumer.

Since that time the service has undertaken improvement activities including providing staff training on the management of urinary tract infections, auditing infection rates, increasing the numbers of staff with specialist infection control training and conducting an inventory on the numbers of lifting slings required.

The Assessment Team found that that the service has practices to promote appropriate antibiotic prescribing and the service is proactive in conducting pathology testing and setting up PPE stations for consumers who require it. The Assessment Team identified one consumer where signage to update staff about the mode of transmission had not been updated and the consumer’s door was kept open.

The Assessment team also identified a number of items that were visibly not clean. This included, but was not limited to, mechanical lifting equipment, lifting slings and trolleys which are shared items. With regard to lifting equipment, the Assessment Team observed numerous lifters around the service which had slings draped over them and it was not evident whether these slings had been being wiped and disinfected prior to use by another consumer. The DOC advised the Assessment Team during the site visit that the service had previously identified the issue of shared equipment and was currently ordering new slings to ensure each consumer had their own.

The Approved Provider provided a response to the Assessment Team’s report and supplied further information in relation to this requirement.

Regarding signage indicating mode of transmission in relation to one consumer, the Approved Provider indicated that the consumer’s test results had come back on day two of the assessment contact and suggested the Assessment Team may have passed by the consumer’s door before signage could be updated by staff. Additionally, the Approved Provider supplied care planning documentation showing that the risk of maintaining the consumer’s door open had been risk assessed having taken into account the psychological disposition of the consumer and the infection risk posed. A decision had been taken to leave the door open as the spread of infection was being managed.

With regard to the Assessment Team finding items that were visibly not clean, the Approved Provider provided a cleaning schedule and stated that shared items and items in consumer’s rooms are regularly cleaned. In relation to concerns about the use of lifting slings not being cleaned between consumers, the Approved Provider stated that the Assessment Team had not directly observed slings being used between consumers without being cleaned. The Approved Provider stated that staff are aware of their responsibilities to wipe down slings before returning the lifter to the storage area and were doing this. The Approved Provider also provided documentation showing that individual slings for each consumer that needed one had been purchased in July 2023 and delivered on 11 August 2023 showing the issue had been addressed.

Having considered the information provided by the Assessment Team and the Approved Provider, I am satisfied Requirement 3(3)(a) is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

Requirement 6(3)(d)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were the Assessment Team reported that complaints data was not being effectively captured/recorded, trended or utilised. Consumers were unable to describe changes made as a result of feedback/complaints. Management staff said no trends in complaints data were identified; however, acknowledged effective documentation of complaints did not occur and demonstration of resolution was not evident. In their response to the Assessment Team’s report, the Approved Provider acknowledged the feedback and complaint management processes required strengthening and advised of actions planned to address this.

Since that time the service has undertaken improvement activities including reviewing policies and procedures and response times, displaying feedback forms more prominently and discussion of complaints at clinical governance meetings.

The actions taken in response to the non-compliance have been ineffective.

Complaint records provided by the service included information showing actions are taken to resolve most, but not all, individual complaints. Several complaints had not been either adequately reported or concluded satisfactorily.

It was not demonstrated that feedback and complaints have been used to improve the quality of care and services. A review of the service’s current Plan for Continuous Improvement shows only one of the 34 entries in 2023 has feedback or a complaint as the source of the improvement (with the other sources predominantly being internal audits and management initiatives). That one entry was added recently in July 2023. Analysis and trending of complaints prior to July 2023 was not demonstrated and no systemic improvements from feedback or complaints were demonstrated for 2023 to date. A review of the service’s clinical governance and risk committee meeting minutes for 2023 show information about complaints is tabled, but no trends or related improvements were identified. Review of the service’s feedback register shows a trend in complaints about the behaviour of consumers impacting on others. The Assessment team found that the service had not identified this trend and it was not identified in the service Continuous Improvement Plan.

The Approved Provider provided a response to the Assessment Team’s report and supplied further information in relation to this requirement.

The Approved Provider, in their response to the Assessment Team’s report, stated that seldom is feedback received that relates to the whole service. It is usually an individual issue specific to a consumer which explains why it does not appear in the Continuous Improvement Plan. The Approved Provider produced information describing what they had done, and are still doing, to resolve the one complaint that was entered into the services Continuous Improvement Plan in July 2023. They stated this issue was raised by a consumer, formalising into the feedback register and moved to the Continuous Improvement Register to drive improvement.

The Approved Provider stated not all issues raised through a complaint will be appropriate for the Continuous Improvement Register but they are still actioned appropriately. Information was produced showing how a range of complaints and feedback had been addressed. This included information about two complaints received about overcharging for pharmacy in early August 2023. This issue was identified by consumer representatives, not the service or the pharmacy, but no evidence was provided by the Approved Provider to demonstrate whether a full investigation had occurred to see that this issue had affected other consumers which, given the nature of the issue, seemed highly likely.

The information provided by the Approved Provider in relation to complaints received also did not demonstrate consumer involvement in finding solutions to issues they have raised. For example, there were two complaints/feedback received about overcrowding at a function and the desire to request different music at events put on by entertainers but no evidence of consumer involvement in finding solutions to these issues.

Whilst complaints raised may be individual there will be themes that can and should be identified to drive improvements to safety and quality systems. Consumer involvement is key to finding solutions to issues they have raised to make improvements to the service.

Having considered the information provided by the Assessment Team and the Approved Provider, Requirement 6(3)(d) is found Non-Compliant.

# Standard 7

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| Human resources | |  |
| 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

Requirement 7(3)(c)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were the Assessment Team reported a lack of effective systems to ensure a competent workforce with knowledge to perform their roles competently.

Since that time the service has undertaken improvement activities including developing a training plan for the delivery of staff education. The actions taken in response to the non-compliance have been effective.

Staff interviewed advised they have qualifications and position descriptions relevant to their roles. Staff capabilities have been determined and staff competency assessments take place. Personnel files reviewed demonstrated relevant competency assessment records.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 7(3)(c) is Compliant.

Requirement 7(3)(d)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were the Assessment Team reported a lack of effective systems to ensure staff are trained, equipped and supported to deliver outcomes required by the Quality Standards.

Since that time the service has undertaken improvement activities including developing a training plan for the delivery of staff education.

The actions taken in response to the non-compliance have been ineffective.

Orientation is occurring for new staff and most mandatory training is being completed by most staff. Some mandatory training topics have not been completed by some staff. Other training is being completed by staff and some staff demonstrated related learning. Related learning was not demonstrated by some staff in the areas of SIRS reporting, restrictive practice, the provision of personal care and treating consumers with respect.

Staff and most the consumers and representatives thought staff have the training they need, however, two consumers and a representative raised concerns about the training provided to staff. Furthermore, it was not demonstrated the organisation’s recruitment processes have been followed as reference checks could not be supplied for new starters.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 7(3)(d) is found Non-Compliant.

Requirement 7(3)(e)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were the Assessment Team found that while monitoring and review of staff’s performance was demonstrated, the processes were not effective in identifying gaps in skills/knowledge and or additional training required.

Since that time the service has undertaken improvement activities including completing staff competencies and annual performance appraisals for all staff.

The actions taken in response to the non-compliance have been ineffective.

The Assessment Team found that, while staff misconduct issues are being dealt with, this has not led to regular assessment, monitoring and review of the performance of each member of staff involved. Whilst it is acknowledged the service has a plan to address, probationary and annual performance appraisals have not been occurring for all staff.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 7(3)(e) is found Non-Compliant.

# Standard 8

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| Organisational governance | |  |
| 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 |

Findings

Requirement 8(3)(b)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were effective overarching monitoring processes were not demonstrated to ensure a culture of safe, inclusive quality care. While a clinical governance framework was evident, it was not effective at a service level in ensuring consumers’ clinical needs were appropriately addressed. The service was in the process of implementing an electronic organisational governance system, not all policies/procedures to guide staff had been completed, and staff had not been provided with training about the changes. Since that time the service has undertaken improvement activities including reviewing policies and procedures for escalating issues to the Board and improved reporting to the Board on matters clinical and serious incidents.

The actions taken in response to the non-compliance have been effective.

The Board demonstrated they regularly seek information to assure themselves about the quality of care and services provided to consumers and they communicate their expectations about this to staff. Overall, it has been demonstrated the board promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 8(3)(b) is Compliant.

Requirement 8(3)(c)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were effective governance systems were not demonstrated in relation to some aspects of information management or in relation to workforce governance.

Since that time the service has undertaken improvement activities including reviewing policies and procedures and progress in the roll out of the new electronic system and provided staff with training to enable them to perform their roles and responsibilities.

The actions taken in response to the non-compliance have been ineffective.

Whilst effective organisation wide governance systems relating to information management, financial governance and feedback and complaints were identified, these have not been demonstrated in relation to continuous improvement, workforce governance and regulatory compliance. With regard to continuous improvement, workforce governance and regulatory compliance, improvements have not been effective in achieving or sustaining compliance in relation to some of the Quality Standards and Requirements found to be Non-compliant after the Site Audit in August 2022. Board meeting minutes and reports tabled for the board do not show analysis and commentary in reporting about these governance issues to give the board a level of visibility to know about these aspects of service performance. Regulatory compliance is not maintained in relation to the SIRS reporting and restrictive practices.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 8(3)(c) is Non-Compliant.

Requirement 8(3)(d)

An Assessment Team from the Commission undertook a Site Audit at the service in August 2022 and following this a decision was made that this Requirement was Non-compliant. The reasons were effective risk management systems were not demonstrated in relation to the clinical care of consumers, effective management of HIHP risks associated with the care of consumers or supporting consumers to live their best life. In their response to the Assessment Team’s report, the Approved Provider refuted some of the information and advised of the work underway to address acknowledged deficits.

The actions taken in response to the non-compliance included commencing performance reviews for all clinical staff, undertake staff training to address knowledge gaps and regularly review high impact high prevalence incidents.

The actions taken in response to the non-compliance have been ineffective.

Whilst there are systems and practices to support organisational risk management in relation to supporting consumers to live the best life, they can these are ineffective in relation to managing high impact, high prevalence risks, risk management regarding abuse of consumers and incident management.

While some information is being presented to the board about high impact, high prevalence risks associated with the care of consumers, some of the data is inaccurate and there is a lack of analysis and commentary about the effectiveness of related risk management.

It is not evident that the board is able to have effective oversight of risk management regarding high impact, high prevalence risks or risk management regarding abuse of consumers and incident management. Gaps and issues found by the Assessment Team relating to the management of risk have not been identified through the organisations own quality management systems.

The Approved Provider provided a response to the Assessment Team’s report but did not supply any further information in relation to this requirement.

Having considered the information provided by the Assessment Team, Requirement 8(3)(d) is Non-Compliant.

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)