Performance

Report

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| Name: | Eyre Peninsula Old Folks Home |
| Commission ID: | 6046 |
| Address: | 26 Flinders Highway, PORT LINCOLN, South Australia, 5606 |
| Activity type: | Site Audit |
| Activity date: | 21 November 2023 to 23 November 2023 |
| Performance report date: | 29 January 2024 |
| Service included in this assessment: | Provider: 174 Eyre Peninsula Old Folks Home Inc  Service: 4063 Eyre Peninsula Old Folks Home |

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 Eyre Peninsula Old Folks Home (**the service**) has been prepared by R Beaman, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others; and
* the provider’s response to the assessment team’s report received 20 December 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 | **Compliant** |
| **Standard 8** Organisational governance | **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.

* Standard 2 Requirement (3)(a): Ensure assessment and planning considers risks to consumers’ health, and well-being, including undertaking activities of risk, to inform the delivery of safe and quality care and services.

# 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

The assessment team recommended Requirement (3)(d) in this Standard not met as consumers who undertook activities of risk were not supported to undertake those activities in a safe manner. Risk assessments were not completed consistently to develop strategies to mitigate the risks. The assessment team’s report included the following information and evidence gathered through documentation, interviews, and observations relevant to their recommendation:

* Consumers interviewed felt supported to live their best life and felt their choices to take risks were not restricted.
* Four consumers who undertook activities of choice that involved risk confirmed staff had not had a discussion with them about risks, including those involved when driving a vehicle, consuming foods not recommended, or foods consumed that have a negative impact on health conditions.
* One of the four named consumers did not have a risk assessment undertaken to consider their activity of choice or any risks associated with their administered medications.
* The service’s Choice and Risk policy records risks and the potential consequences will be discussed with consumers. including ways to mitigate the risks. The consumer handbook documents a letter will be signed by consumers who undertake risk activities to acknowledge the risk discussion has occurred.

The provider acknowledged the assessment team’s report and included the following additional information and actions taken in their response:

* Completing risk assessments for consumers undertaking activities of risk.
* Review of the current risk form to ensure all potential risks are captured.
* Update the risk assessment policy and procedure.
* Complete a risk assessment audit to identify any missed data.

I acknowledge the actions taken by the provider and the information in the assessment team’s report, however, I have come to a different view to that of the assessment team and find the service supports consumers to take risks where they choose to, to live their best life. In coming to my finding, I have considered and placed weight on the information in the assessment team’s report stating all consumers sampled confirmed they are supported to live the best life they can and do not feel their choice of activities where there is risk involved is restricted. I have also considered that three consumers confirmed they had discussions with staff about the risks involved in their chosen activity and acknowledge that not all consumers have been involved in discussions. However, I have considered the omission of risk assessments or discussion of risk for some consumers undertaking activities of risk in Requirement (3)(a) of Standard 2 which includes consideration of risk in planning consumer care.

For the reasons above, I find Requirement (3)(d) in Standard 1 compliant.

In relation to Requirements **(3)(a), (3)b), (3)(c), (3)(e), and (3)(f),** consumers confirmed they were treated with dignity and respect, felt their choices were acknowledged, and their privacy respected. Consumers and representatives were satisfied care and services were delivered in a way that respected consumers’ choices and was culturally safe. Documentation confirmed consumers’ choice were recorded and communicated with other providers of care.

Staff demonstrated understanding of consumers’ cultural needs and diversities and described ways they deliver care and services that meets those needs, goals, and preferences. Staff described ways in which they support consumers to make choices about their own care and services, including who they wished to be involved in those decisions. Staff were observed being respectful of consumers’ privacy and dignity during the delivery of care.

Consumers’ information was observed to be kept confidential through a password protected electronic management system.

For the reasons detailed above, I find Standard 1 Consumer dignity and choice compliant.

# 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 assessment team recommended Requirements (3)(a) and (3)(e) not met as assessment and planning process were not effective in relation to the consideration of risks and assessment and planning was not regularly reviewed.

**Requirement (3)(a)**

The assessment team’s report includes the following information and evidence gathered through documentation, observations and interviews relevant to my finding:

* Two consumers who wish to undertake activities of risk did not have a risk assessment undertaken in relation to their risks. For one consumer who wished to consume alcohol, staff had not undertaken a risk assessment in relation to the consumption or considered the effects it may have on administered medications. There was no evidence discussion had occurred about risks involved with the consumer or their representative.
* For the other consumer, staff did not undertake a risk assessment or have discussions with the consumer or their representative around the risks involved with their preference to have food that has potential risks to their health and well-being as the result of their medical condition.
* Pain assessments are completed for consumers on admission, however, where consumers experience pain, there were no strategies documented to manage pain or process in place to guide staff to review pain.
  + Three consumers did not have their pain assessed appropriately. For one consumer who experiences pain, pain was not appropriately assessed to develop strategies to manage pain effectively. The consumer was administered as required pain relief medication on multiple occasions between August and October 2023 with no pain charting to identify alternative strategies to manage pain.
  + Another consumer, who has necrotic wounds, was documented as complaining of pain at the wound site and they could not sleep because of it. Whilst additional pain medication was issued, staff did not assess their pain to determine if current strategies were effective.
  + One palliative consumer who was refusing oral pain relief medications multiple times during October 2023 and had incidents of physical aggression during activities of daily living did not have pain charting to assess their pain or monitor or evaluate the effectiveness of pain strategies.
* Wound assessments did not consistently include measurements or photographs to indicate size of a wound to determine if it was healing or deteriorating. For one consumer, there was no current wound management plan in place to guide staff, and for two consumers there were no accurate measurements or clear photographs to show the wound and inconsistency in documentation in relation to wound dressings.

The provider did not agree with most of the findings in the assessment team’s report and provided additional information and commentary in their response. The provider’s response included pain monitoring charts and assessments for the named consumers, along with wound management plans for the two consumers identified as not having those. I acknowledge the provider’s response and the additional information included, however, I find assessment and planning processes do not always consider risk to inform the safe delivery of care and services.

In coming to my finding, I have considered information in Requirement (3)(d) in Standard 1 in relation to consumers not having risk assessments in place prior to their activity of choice or that discussions of risks are being undertaken with consumers about risks and mitigation strategies. The provider asserts risk information is included in the domains within consumer care documentation and provided a risk register with consumers’ risk activities, strategies to mitigate risk and a review date. I acknowledge the provider’s assertion; however, this information does not show that assessment and planning is effectively or consistently considering risks through a risk assessment process.

I have also considered information in the assessment team’s report, including feedback provided by four consumers stating they had not had a discussion with staff about their activity of risk or mitigation strategies. The provider asserts consumer care plans are discussed and provided additional information to show those discussions were advised and would occur. However, this information is not confirmation a risk assessment of activities of risk occurred or would occur, and the assessment team’s report confirms through feedback and observations consumers were currently undertaking activities of risk.

In relation to the management of wounds I have considered this information in Requirement (3)(e) of this Standard.

I acknowledge the actions the provider has taken following the site audit visit but find they will need time to embed those processes for efficacy and encourage the provider to continue to do so.

For the reasons above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(e)**

The assessment team’s report includes the following information and evidence gathered through documentation, observations and interviews relevant to my finding:

* Documentation confirmed regular reviews of consumer care plans occurred as per the service’s schedule, however, care and services are not consistently assessed or reviewed when change occurs, including following an incident when the needs of the consumer are impacted.
* Three consumers have multiple incidents, including changed behaviours, falls and pain in relation to wounds. For one consumer with multiple incidents of changed behaviours during August 2023, pain and infection was not considered and strategies in the behaviour support plan were not reviewed.
  + One consumer with several falls between May and June 2023 had no review of falls prevention strategies to minimise the risk of further falls.
  + One consumer who complained of pain at the site of a necrotic wound at the time of the site audit visit did not have charting to identify new or current pain or a review of their pain assessment to determine the effectiveness of current strategies.

The provider did not agree with most of the assessment team’s findings and included additional commentary and information in their response, including pain charting for consumers experiencing pain, reviews by the medical officer and allied health for the consumer experiencing falls, with the falls risk assessment completed and included. For the consumer with multiple adverse behaviours, the provider acknowledges the deficits identified in the assessment team’s report in that not all incidents have been recorded and provided actions they have taken and planned to rectify the deficits.

I acknowledge the information in the assessment team’s report; however, I have come to a different view and find the service does regularly review assessments for consumers, including when changes or incidents occur. In coming to my finding, I have considered the additional information and commentary in the provider’s response in relation to the consumers experiencing pain and find this shows regular assessment of pain for the two named consumers, and the consumer experiencing pain from a necrotic wound. I have also considered feedback from consumers and their representatives that confirms staff review consumer care plans regularly and when incidents occur, representatives confirmed they are advised and kept updated.

I have considered the information in the assessment team’s report in relation to incidents of adverse behaviour for one consumer not being recorded as an incident consistently and place weight on the actions taken by the provider to rectify those practices of staff through further education. I don’t find this occurrence is systemic and the service has a process in place to review consumers’ care and services at regular intervals and is further supported by policies and procedures.

For the reasons above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

In relation to **Requirements (3)(b), (3)(c), and (3)(d),** consumers and representatives were satisfied care and services were current and reflective of consumers’ needs, goals and preferences, consumers were partners in developing their care and services and outcomes of those were communicated effectively and consistently. Documentation confirmed consumers had input into their own care and services through regular discussion and those outcomes were communicated in various ways to consumers and staff. Care plans sampled reflected consumers’ current needs, goals and preferences and where appropriate included advance health directive information. Staff described ways in which they involved consumers in developing their care and services and to ensure outcomes of care planning and assessments are communicated to consumers and their representatives where appropriate.

For the reasons above, I find **Requirements (3)(b), (3)(c), and (3)(d)** in Standard 2 Ongoing assessment and planning with consumers 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. | 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

Consumers and representatives were satisfied care is delivered in a safe manner and is tailored to individual consumer’s needs, goals, and preferences. Consumers confirmed they felt staff understood their needs and managed their health risks effectively. Consumers and representatives confirmed staff respond to any changes in consumers’ condition or incidents appropriately and they are referred to other health and medical service providers when needed.

Consumers and representatives were satisfied the information about consumer care is communicated effectively, confirming staff know consumers well and they don’t have to repeat their needs, goals and preferences for care and services to other providers of care.

Documentation showed where deterioration is detected, there are processes in place to manage consumers safely and effectively. Documentation showed there are effective processes in place for timely referrals for consumers to other providers of care, including medical officers and allied health professionals. End of life needs, goals and preferences are respected, recorded, and communicated and the consumer’s comfort and dignity maximised.

Staff were knowledgeable of consumers’ needs, goals, and preferences in relation to personal and clinical care, how they manage risks and communicate any changes in condition to other providers of care. Staff confirmed they receive information about consumers’ personal and clinical care needs, including any changes through the handover process which occurs at commencement of every shift. Staff conformed they receive regular infection control training and updates and were knowledgeable of the processes in place to minimise the spread of infection. Staff were observed adhering to infection control principles, with appropriate personal protective equipment worn throughout the duration of site audit visit.

Based on the information above, I find Standard 3 Personal care and clinical care compliant.

# 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

Consumers and representatives confirmed consumers are supported to engage in the lifestyle program and those supports enable consumers to maintain their independence and optimise their health, well-being. Consumers confirmed staff provide additional support when they feel they need it and were satisfied their spiritual needs were respected. Consumers and representatives were satisfied consumer information is communicated effectively and confirmed consumers don’t need to repeat information when care is delivered by other service providers. Consumers confirmed they can do things that interest them and are supported to maintain connections with those they choose.

Consumers and representatives reported satisfaction with the quality and quantity of meals and although some consumers reported issues with food in the past confirmed there has been improvements in the quality of meals in recent times. Documentation confirmed food satisfaction surveys are completed and resident relative meetings include food discussions with feedback used to improve the quality of food. Staff described the ways they provide emotional support to consumers when they observe them in a low mood or appear sad and were observed providing emotional support to console a consumer who was upset and crying about missing their loved one.

Documentation sampled reflected consumers’ likes, dislikes and requirements for meals and activities, and recorded strategies to support their emotional, spiritual, and psychological needs.

Equipment used as part of consumers’ engagement with lifestyle and maintaining their independence was observed to be clean, safe, and well-maintained.

Based on the information above, I find Standard 4 Services and supports for daily living compliant.

# 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

The assessment team recommended Requirement (3)(b) not met as they were not satisfied consumers could move freely outdoors. The assessment team’s report includes the following information and evidence gathered through documentation, observations, and interviews relevant to my finding:

* Six consumers in one wing of the service provided feedback indicating they were not satisfied they could access outdoor areas when they wished to. Three of the six consumers advised they could access outdoor areas if they asked staff.
* One consumer confirmed they could access the outdoor areas from their room as they had a key and pin codes to exit the service. Two consumers advised they did not know the pin codes.
* Management advised pin codes for external doors are disabled each morning and demonstrated how this is done. The assessment team observed the pin codes had not been disabled on the first and second day of the site audit visit.
* An environmental audit completed in June 2023 showed access to the outdoor areas being difficult for consumers had been raised previously and recorded the main entrance door was kept unlocked for consumers to exit but locked to enter for safety reasons.
* Five green exit buttons were observed on external doors. Staff advised these were initially to allow people to access from outside the service but disabled for safety reasons.
* Consumers were observed having morning tea in outdoor areas, including the balcony with the doors to access left ajar for consumers to go in and out freely. Two entry points of the memory support wing were locked. Staff advised they open and keep them open when weather permits otherwise they are closed and locked and consumers need to be assisted to access outdoor spaces.
* Care staff advised they need to accompany consumers to the outdoor areas whenever they wish and need to use a pin code to access those areas.
* Management opened the doors to the non-memory support wing on the final day of the audit with signs placed at the doors stating unlocked between 8:00am and 5:00pm. Management advised they identified a malfunction on other doors that had been observed locked with a contractor engaged to fix that immediately.
* On the final day of the site audit visit, two consumers who had provided feedback were observed moving freely indoors and outdoors.
* Six consumers stated they were satisfied the service environment was clean, safe, and well maintained.
* Staff advised they have weekly cleaning schedules to guide them which was observed on the cleaning trolley with a signed checklist to show tasks completed.
* The service environment was observed to be clean and comfortable, with all consumers having heating and cooling systems in their bedrooms.

The provider did not agree with most of the findings in the assessment team’s report and included additional information and commentary in their response. The provider asserts all consumers who reside in the non-secure wings of the service have doors in their rooms that enable them to access the outdoor areas freely whenever they wish. The provider asserts all consumers are given keys on admission to lock and unlock their own doors whenever they wish and included commentary in relation to two named consumers stating they have been observed using their keys to unlock their bedside drawers, using their balconies, and using the outdoor areas and asserts they are able to move freely outdoors when they wish to do so and are able to use their keys. The provider acknowledged the issues identified by the assessment team in relation to locks not working appropriately to enable consumers to use outdoor spaces and provided actions taken to address those.

I acknowledge the information in the assessment team’s report; however, I have come to a different view and find consumers are able to move freely indoors and outdoors. In coming to my finding, I have considered the information in the assessment team’s report in relation to the doors being observed locked on one occasion and place weight on the actions of the provider to immediately rectify those issues which was also noted in the assessment team’s report. I acknowledge some consumers provided feedback that indicated dissatisfaction with not being able to access outdoor spaces and note other consumers were observed or provided feedback indicating they had access to outdoor areas. I have also considered information in other Requirements in Standard 5 that includes consumers were observed using the outdoor areas throughout the service.

I acknowledge the actions the provider has taken during and immediately following the site audit visit to rectify issues in relation to consumers accessing outdoor areas and encourage them to continue with those.

For the reasons above, I find Requirement (3)(b) of Standard 5 Organisation’s service environment compliant.

In relation to **Requirements (3)(a), and (3)(c),** consumers and representatives confirmed the service environment is welcoming and consumers were satisfied with the cleanliness and maintenance and were able to navigate around the service once they were oriented. The service environment was clean and well maintained and staff described ways in which they escalate issues requiring maintenance in a timely manner. Staff described the maintenance system and how items are reported by staff or consumers to be reviewed and fixed. Documentation confirmed a cleaning schedule is maintained and all areas of the service are regularly cleaned. The service has a routine and preventative maintenance schedule that was regularly reviewed via an audit schedule.

For the reasons above, I find Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment compliant.

# 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

Consumers and representatives confirmed they are encouraged to and felt supported to provide feedback in various ways about care and services, including via written feedback forms that are readily available throughout the service, through the suggestion boxes located around the service, directly to staff and management, or via resident experience surveys. Consumers confirmed where they make a complaint their issue is promptly dealt with, and staff or management apologise if something has gone wrong.

Information about how to make complaints, accessing advocacy and other language services to raise complaints was observed throughout the service for consumers and representatives to access. Documentation confirmed consumers are encouraged to provide feedback during resident relative meetings.

Staff demonstrated understanding of the service’s feedback system and described ways they support and assist consumers to provide feedback and raise complaints, including escalating concerns given to them verbally to their supervisor, assisting consumers to complete feedback forms and documenting when consumers raise concerns with them.

Management described ways they use feedback and complaints provided by consumers to drive the service’s continuous improvement giving specific examples of projects that have been implemented directly from consumer feedback.

For the reasons detailed above, I find Standard 6 Feedback and complaints compliant.

# 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. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The assessment team recommended Requirements (3)(c), (3)(d) and (3)(e) in this Standard not met. The assessment team were not satisfied staff were competent in their roles, that training was effective, or staff performance was monitored effectively to deliver quality care and services. However, I have come to a different view to that of the assessment team and have included my reasons with the specific Requirements below.

**Requirement (3)(c)**

The assessment team were not satisfied the service’s processes for monitoring staff competency were effective and deficits in staff practice identified across care and services, including a lack of understanding of their requirements under the Serious Incident Reporting Scheme (SIRS), undertaking risk assessments and restrictive practices. The assessment team’s report included the following information and evidence gathered through interview and documentation relevant to their recommendation:

* Staff did not document non-pharmalogical interventions prior to medication administration for behaviour management for two consumers.
* Staff did not consider several consumers were subject to environmental restraint when they were unable to access outdoor areas freely.
* Training documentation indicated staff had undertaken SIRS training 12 months prior to the site audit visit, however, staff were unable to provide examples of reportable incidents.
* Staff did not record consumer pain effectively where pain was experienced.
* Staff did not show understanding of risk management and where consumers undertook activities of risk, they did not complete risk assessments to mitigate harm to the consumer.
* An effective system to monitor the competencies of staff to deliver care and services safely was not demonstrated.
* The service had an Infection Prevention Control lead in place and kitchen and hospitality staff demonstrated competency with food safety processes.

The provider acknowledged the assessment team’s report but did not agree with all of the findings. The provider also included additional information and commentary in their response in relation to the deficits identified in the assessment team’s report, including education to all staff in relation to SIRS. The provider asserts that clinical staff undertake risk assessments when required for consumers and included evidence with their response to show pain charting is completed for consumers where it is required. Whilst the provider did not agree with the assessment team’s findings in totality, they used the information in the report as an opportunity to identify ways to improve, including additional training in wound care.

I acknowledge the information in the assessment team’s report, however, have come to a different view and find staff are competent and have the qualifications and skills to effectively perform their roles. In coming to my finding, I considered that service demonstrated they deliver safe and effective clinical care to consumers and there were no concerns raised in Standard 3 in relation to the way in which staff performed their roles. I have also considered information in Requirement (3)(d) in Standard 8 that shows staff managed high impact or high prevalence risks to consumers’ care effectively as evidence of staff competency. Whilst staff were unable to describe a specific reportable incident to the assessment team or discuss the training they received in detail; I have not been provided evidence to show this is due to competency.

For the reasons above, I find Requirement (3)(c) in Standard 7, Human resources compliant.

**Requirement (3)(d)**

The assessment team were not satisfied the service’s processes for onboarding and training staff were effective. The assessment team’s report included the following information and evidence gathered through interview and documentation relevant to their recommendation:

* Clinical and care staff felt requests for training are not responded to in a timely manner and requests for palliative care and diabetes management training by care staff have not been actioned.
* Seven staff members stated training requests are addressed.
* One staff member felt they did not have enough training in relation to supporting consumers living with dementia and another stated they are not receiving manual handling training.
* Training records showed a low training completion rate for staff and management could not demonstrate how the service monitors compliance for staff training.
* Onboarding processes for new staff were not identified and checklists and training was not provided. Staff files reviewed did not show onboarding or training had been completed.
* Management could not demonstrate how training needs are identified for staff.
* The service was able to show they had an effective process in place for recruitment ensuring staff have appropriate qualifications to undertake their designated role.

The provider did not agree with all of the findings in the assessment team’s report, however, acknowledged they had identified areas for further improvement. The provider’s response included additional commentary and information in relation to this Requirement. The provider asserts they had received no requests for additional training and provided evidence they added additional dementia and diabetes management training to their training calendar for all staff to access. I acknowledge the information in the assessment team’s report; however, I find the service’s workforce is recruited, trained, and equipped to deliver the outcomes required by the Quality Standards.

In coming to my finding, I have considered the evidence in Standard 3 that shows staff are delivering safe and effective personal and clinical care to consumers who confirmed staff know them well and they are satisfied with their care delivery. I have considered and place weight on the information included in the provider’s response that shows the service has an embedded onboarding process and a dedicated clinical lead nurse with oversight of the training program, along with evidence that shows training has been completed by staff.

I acknowledge the actions the provider has taken since the site audit visit to enhance their workforce training in areas, including wound management, SIRS, risk assessment and restrictive practices and I encourage them to continue with those.

For the reasons above, I find Requirement (3)(d) in Standard 7 Human resources compliant.

**Requirement (3)(e)**

The assessment team were not satisfied the service’s processes for monitoring staff performance were effective, including regular assessment and staff appraisals. The assessment team’s report included the following information and evidence gathered through interview and documentation relevant to their recommendation:

* Management confirm they provide staff feedback about their performance through informal conversations that are not documented and acknowledged they were behind on conducting annual staff performance appraisals.
* Two personnel files sampled confirmed a performance appraisal was completed with an evaluation of performance, but the appraisal did not identify training needs of the staff member or training the staff member wished to receive.
* Four staff members advised they had raised concerns with management about the conduct of another staff member towards consumers and nothing was actioned with the staff member still working at the service.

The provider did not agree with the findings in the assessment team’s report and provided additional commentary and information in their response that included performance discussions and management is undertaken where staff practice does not meet the service’s expectations. The provider asserts they undertake regular review of staff performance and have ongoing discussions with staff that include feedback about their performance.

I acknowledge the information and findings in the assessment team’s report, however, I have come to a different view and find the service regularly reviews and monitors the performance of their workforce. In coming to my finding, I have considered and placed weight on the information in the assessment team’s report that includes evidence of performance management being undertaken where a deficit in staff practice was identified. Whilst training needs were not explicit on the performance appraisal form, I am not persuaded this indicates staff monitoring is not effective. Information in the assessment team’s report confirms an evaluation of staff practice occurs and the provider’s response included additional commentary asserting informal discussions occur regularly with staff. I have also relied on the information in Standard 3 that shows staff practice is effective when delivering personal and clinical care as an indicator regular assessment of their work occurs.

For the reasons above, I find Requirement (3)(e) in Standard 7 Human resources compliant.

In relation to Requirements **(3)(a) and (3)(b),** consumers and representatives felt there were enough staff to deliver care and services in a way consumers wished and their needs, goals, and preferences are met. Consumers confirmed staff treat them in a kind and caring manner and deliver care in a respectful manner. Staff were observed interacting with consumers in a positive, kind, and caring manner throughout the site audit visit.

Staff were knowledgeable of consumers’ preferences for care delivery and described ways in which they tailor care to consumers’ needs. Staff confirmed they are supported to undertake their roles with enough staff allocated to do their roles effectively. Documentation confirmed the service has a process in place to identify the number and mix of staff needed to deliver care and services effectively, along with a process to ensure all shifts are filled.

For the reasons above, I find Requirements (3)(a) and (3)(b) in Standard 7 Human resources compliant.

# 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. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The assessment team recommended Requirements (3)(c), (3)(d) and (3)(e) in this Standard not met. The assessment team were not satisfied the organisation had effective clinical governance or risk management systems in relation to incident management, or that the organisation’s governance was effective in relation to workforce governance and information management.

**Requirement (3)(c)**

The assessment team were not satisfied the organisation’s governance systems were effective in relation to information management, specifically not capturing risks associated with consumer care on incident forms, and workforce governance in relation to systems and processes to ensure staff are appropriately trained and monitored. The assessment team’s report included the following information and evidence gathered through observation, interview, and documentation relevant to their recommendation:

* Processes to monitor staff competency and training were not effective. Staff were unable to describe information relating to SIRS or restrictive practices.
* The service has processes to recruit appropriately qualified staff, however, did not have an effective onboarding process and staff or management could not describe mandatory training requirements.
* Effective processes in relation to monitoring staff performance were not demonstrated and some staff raised concerns about staff performance that was reported but not actioned.
* Information around risk was not always captured on consumer care documentation to guide staff to support consumers wishing to take risks.
* Information in relation to incidents is not consistently completed in a timely manner.
* The service has an effective process in relation to financial governance, feedback and complaints and senior leaders monitor any regulatory or legislative changes to maintain regulatory compliance. A plan for continuous improvement is in place with actions to improve care and services identified.

The provider acknowledged the information in the assessment team’s report and did not agree with all findings. The provider asserts they have a process in place to ensure staff are competent in their roles, appropriately trained and monitored, including an onboarding process that has clinical leadership as oversight of that. The provider included evidence in their response to show they undertake regular assessment of staff performance and manage staff where issues or concerns are raised or identified. In relation to information management, the provider acknowledges incident forms can remain open for a period of time and asserts this is their practice whilst incident investigations are undertaken by clinical staff.

I acknowledge the information in the assessment team’s report; however, I find the service demonstrated its organisational governance is effective. In coming to my finding, I have considered information in the assessment team’s report included in Standard 7 that shows the service has a system in place to ensure the workforce are appropriately skilled and qualified to undertake their roles, and consumer feedback indicated satisfaction with the way in which staff deliver care and have knowledge of their needs. In relation to workforce governance, I have also considered and placed weight on the information in the provider’s response that shows staff are monitored through regular assessment and they receive mandatory and additional training where needs are identified which indicates they do not have a systemic issue in governance.

In relation to information management, I have considered the deficits identified in the assessment team’s report in Requirement (3)(d) of this Standard.

For the reasons above, I find Requirement (3)(c) in Standard 8 Organisational governance compliant.

**Requirement (3)(d)**

The assessment team were not satisfied the service demonstrated effective risk management systems in relation to incident management, responding to abuse and neglect and supporting consumers to live their best life. The assessment team’s report included the following information and evidence gathered through interview and documentation relevant to their recommendation:

* The service’s policy to support incident management does not provide guidance on timeframes to compete incident reports and staff do not complete incident forms for extended periods of time, sometimes up to six weeks.
* Several incidents were identified that had not been recorded as incidents through the incident management system. Three consumers have had multiple entries on behaviour or wound charting that have not been recorded as incidents, including incidents of physical and verbal aggression.
* Some incidents are reported but not always followed up in a timely manner and remain unfinalised in the incident management system for extended periods. Management advised incidents remain open for review and they rely on staff informing them of incidents to ensure follow up occurs. Management advised there was no monitoring process in place to ensure all incidents are captured and reported.
* Two named consumer who had various incidents over a three month period, including falls had their care plans reviewed post incidents but did not record any new strategies to prevent falls.
* One consumer had a medication incident which was not identified for 24 hours by staff, management were not aware for almost two weeks and the medical officer was not informed of the incident.
* Risk assessments are not completed for all consumers wishing to take risks to live the life they choose.
* Staff could not describe how they recognise and respond to abuse and neglect of consumers or the training they had undertaken in relation to elder Abuse or SIRS.

The provider did not agree with all the findings in the assessment team’s report and included additional information and commentary in their response. The provider acknowledged that whilst not all risks were transcribed to a specific risk assessment form, this is not the organisation’s procedure. However, the provider asserts risks are captured and recorded in each domain of the consumer’s care plan and discussed with consumers and if appropriate their representative during care plan development.

I acknowledge the assessment team’s report, however, I find the organisation has an effective risk management system in place. In coming to my finding, I have considered information in the assessment team’s report that includes the risk management system was effective in the management of high impact or high prevalence risks associated with the care of consumers, including the management of falls, weight loss, behaviour, and pain. In relation to risk assessments not being completed consistently, I have not been provided evidence this is an issue with the organisation’s governance systems and have considered this information in Requirement (3)(a) of Standard 2.

In relation to the service’s incident management system, I acknowledge the information in the assessment team’s report that included incidents were not always recorded or those that were, were not always finalised in a timely manner, however, I have not been presented evidence to show this is a systemic failure in the organisation’s risk management processes. In relation to recognising and responding to abuse and neglect, I have not been provided evidence that indicates this is system and information in the assessment team’s report does not indicate issues of abuse or neglect are not reported or that they have occurred.

For the reasons above, I find Requirement (3)(d) in Standard 8 Organisational governance compliant.

**Requirement (3)(e)**

The assessment team were not satisfied the service demonstrated an effective clinical governance framework in relation to the minimisation of restraint, specifically environmental and policies and procedures did not guide staff effectively in the delivery of safe clinical care. The assessment team’s report included the following information and evidence gathered through interview and documentation relevant to their recommendation:

* The organisation has policies and procedures in place, but they do not provide appropriate direction for staff to undertake effective clinical care.
* Clinical policies are generic, and guidance provided to staff was not specific. The Wound Assessment policy updated in February 2023 informed staff on what information to complete but did not include information about wound photographing, updating the wound management plan or when a wound should be referred to a specialist for review.
* The Restrictive Practices policy does not differentiate the five forms of restraint and only covers physical and environmental restraint. The policy does not provide staff guidance on recognising restrictive practices and meeting the required legislative guidelines.
* Clinical and care staff did not demonstrate knowledge or understanding of minimising use of restraint, specifically environmental restraint.
* Consumers residing in the memory support wing have an environmental restraint in place which includes all requirements as per legislation. However, for one consumer the use of medication was not demonstrated as last resort on 10 occasions where non-pharmacological strategies were not documented prior to administration.
* Monthly clinical data is collected and reported on, however, reports did not indicate tracking and trending of the data and no evidence of discussion about how the service takes steps to minimise clinical incidents was identified.
* Clinical audits are undertaken but did not identify deficits in clinical documentation, including a wound audit undertaken in February 2023 that did not identify missing information on wound charting, including measurements and wound descriptors, or a lack of wound management plans to guide staff.
* A pain management audit undertaken in June 2023 identified one consumer who felt their pain was not managed in line with their preferences but did not identify any improvements.
* Staff were able to describe ways in which they are open and transparent with consumers and representatives when things go wrong.

The provider did not agree with all the findings in the assessment team’s report and included additional information and commentary in their response. The provider asserts clinical data is analysed and reported monthly to the Board for review. The provider’s response included monthly clinical meeting minutes that confirmed discussion and analysis of clinical data for consumers.

I acknowledge the information in the assessment team’s report; however, I find the organisation has an effective clinical governance framework. In coming to my finding, I have considered the information included in Standard 3 that shows consumers are satisfied with clinical care and that is delivered in a safe and effective manner. I have also considered the information in the provider’s response that shows clinical data is reviewed and analysed to identify trends and the use of psychotropic medications are monitored, including as required usage.

In relation to minimising the use of restraint, I have considered the information in the assessment team’s report that shows consumers who reside in a secure area of the service have an environmental restraint in place which shows the service’s governance processes are effective in recognising restraint. I acknowledge for one consumer medication has been used on several occasions where staff have not recorded the non-pharmacological strategies trialled. However, I have not been provided evidence that other aspects of legislative requirements have not been met and find this does not indicate a systemic issue in relation to the service’s clinical governance systems.

For the reasons above, I find Requirement (3)(e) in Standard 8 Organisational governance compliant.

In relation to **Requirements (3)(a) and (3)(b),** consumers confirmed they are actively involved in the development and delivery of care and services through various ways, including resident relative meetings and surveys where they can make suggestions to drive improvements. Documentation showed various ways consumers contribute to care delivery and the development of services, including lifestyle and food.

The organisation has a Board that is accountable for the delivery of quality care and services. Documentation confirmed members of the Board visit the service at regular intervals and interact with consumers and staff. The organisation has various committees that capture and analyse data for the improvement of care and services.

For the reasons above, I find Requirements (3)(a) and (3)(b) in Standard 8 Organisational governance compliant.

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)