Performance

Report

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| Name: | Glenview Community Services Inc. |
| Commission ID: | 8060 |
| Address: | 2-10 Windsor Street, GLENORCHY, Tasmania, 7010 |
| Activity type: | Site Audit |
| Activity date: | 4 June 2024 to 6 June 2024 |
| Performance report date: | 12 July 2024 |
| Service included in this assessment: | Provider: 945 Glenview Community Services Inc  Service: 5311 Glenview Community Services Inc. |

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 Glenview Community Services Inc. (**the service**) has been prepared by M Nicholas, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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.
* the provider’s response to the assessment team’s report received 08 July 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not 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 | **Not Compliant** |

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

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 3**

* Requirement 3(3)(b) implement, maintain, and evaluate planned actions in relation identifying and managing high impact and high prevalence risk.

**Standard 8**

* Requirement 8(3)(e) implement and sustain an effective clinical governance framework and ensure adequate clinical oversight in relation to minimising the use of restraint.

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Consumers and representatives reported staff treat them with respect and provide culturally safe care. Staff demonstrated an understanding of individual consumer choice and cultural preferences and were observed to be treating consumers with dignity and respect. A review of care planning documentation detailed information about consumer background and preferences and reflected culturally safe care and services are provided. The service has policies, procedures, and information available to guide staff in relation to consumer rights and diversity.

Staff described how they support consumers to maintain relationships, make decisions and exercise choice. This was consistent with consumer and representative feedback which indicated the service supports consumers to exercise choice, maintain independence and make decisions about how care and services are provided. The Assessment Team observed staff assisting consumers to maintain relationships with others.

Consumers and representatives reported consumer choices and preferences related to risks are respected. Staff described how they minimise risk to consumers including tailoring solutions to help consumers live the life they choose. Management described processes to support consumer independence and choice. Consumer documentation demonstrated consumers are supported to take risks. The service has a choice and decision-making policy.

Staff described how they communicate with consumers in a way that is easy for the consumer to understand and consistent with consumers’ needs. Consumers and representatives reported they receive information that is accurate, timely and enables consumers to exercise choice. The service has a client liaison officer to facilitate effective communication with consumers.

Staff provided examples of how they ensure consumer privacy and confidentiality is maintained. Consumers and representatives were satisfied their privacy is respected by staff when providing care and their information is kept confidential. The Assessment Team observed confidentiality of consumer information was maintained and staff respected consumer privacy during the Site Audit.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Consumers and representatives reported staff plan care which is safe and meets consumers’ health and well-being needs. Staff described assessment and care planning processes including identifying risk to consumers. Care documentation demonstrated risk to consumer well-being is identified and planning is undertaken to ensure effective care is provided. This included documentation of individualised consumer interventions.

Management demonstrated updates to consumer care plans are undertaken to reflect current consumer needs and preferences following changes being assessed or discussed. Consumers and representatives reported consumer preferences, needs and goals are reflected in care plans, including in relation to end of life care. This was consistent with consumer documentation which demonstrated staff assess and plan care to meet consumer needs and preferences.

Consumers and representatives confirmed they participate in the care planning process. Staff described how they collaborate with consumers, representatives and other providers of care and services to plan consumer care. Consumer documentation reflected the service considers information from other organisations, individuals and service providers when developing consumer care plans.

Consumers and representatives were satisfied with how staff communicate the outcomes of assessments and planning and confirmed they receive a copy of the consumer’s care and services plan. Staff described how they consult with consumers and representatives and confirmed they have access to consumer care documentation through multiple systems.

Staff described how consumer care needs are regularly reviewed including when incidents occur or changes in consumer condition are identified. Consumers and representatives were satisfied the service reviews care and services regularly. Consumer documentation showed regular reviews and reassessment of consumers who had experienced an incident, change in condition or following request by a consumer or representative.

# 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. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirement 3(3)(b) and as a result, does not comply with Standard 3.

Requirement 3(3)(a):

The Assessment Team recommended this Requirement was not met. The Assessment Team found the service did not demonstrate comprehensive management of restrictive practices and care plans did not demonstrate wounds and changed behaviours were effectively managed in accordance with best practice guidelines and organisational policies.

The service did not have an effective process to demonstrate and document informed consent by decision makers for consumers subject to restrictive practices. Consumer restrictive practice authorisation forms did not indicate consumers’ assessed needs or risk of harm for restrictive practices in use. The service did not demonstrate alternative strategies including individualised behaviour support strategies were implemented and monitored for effectiveness prior to and during the use of restrictive practices. Following management feedback and review of clinical documentation and the service’s psychotropic medication register, inconsistent and incorrect identification of restrictive practices was noted by the Assessment Team.

A review of Behaviour Support Plans (BSPs) did not demonstrate assessment processes were undertaken to inform the plan or include individualised information regarding consumer behaviours and strategies to guide staff, identify potential triggers for or the impact of changed behaviours. Consumer BSPs did not consistently outline information about how the restrictive practice should be used, monitored, and reviewed for effectiveness. In response to feedback, management advised they identified deficits in consumers’ BSPs prior to the Site Audit. Management reported they have commenced a plan to address the deficits identified including reviewing and updating all BSPs in consultation with experienced staff. Management provided examples of BSPs which were personalised and detailed behaviour management strategies in relation to restrictive practices. Management confirmed training will be provided to all clinical and care staff on behaviour management and documentation. The psychotropic medication register and consent process for restrictive practices will be reviewed and recorded in the service’s Plan for Continuous Improvement (PCI).

Consumers and representatives reported inconsistencies in wound management provided. A review of documentation demonstrated inconsistent completion of wound charts and wound assessments were not completed in accordance with the organisational policy. However, the Assessment Team noted consumer skin care plans reflected individualised strategies and consultation with medical professionals and specialists. Staff demonstrated an awareness of regular wound monitoring and described interventions to promote skin integrity and the process of escalating clinical issues identified. Management acknowledged feedback and advised deficits in wound management were identified during a recent audit and they plan to share a draft wound management plan with clinical staff. Correspondence regarding deficits in wound management and the service’s plan to address these deficits was sighted by the Assessment Team.

The Approved Provider submitted a response to the Assessment Team report (the response) which included the actions of reviewing policies and procedures related to minimising restrictive practices, psychotropic medication, and behaviour management. The response confirmed the service has a complex care needs register which records chemical and environmental restrictive practices, and it is regularly updated. Behaviour assessments, risk and consent forms will be reviewed to ensure best practice principles are considered and documented within BSPs. A review of BSPs has commenced in consultation with stakeholders and a BSP guide has been developed and distributed to staff. The service has completed a review of consumers subject to chemical restrictive practices and will review assessment and care plans of consumers who are subject to all types of restrictive practices in consultation with medical professionals. The response included the planned action implementing a monitoring process to reduce or stop the use of restrictive practices in consultation with medical officers, representatives, and consumers. Training on psychotropic medication management, behaviour management, BSPs and restrictive practices will be completed in accordance with the service’s training plan. The response detailed a nurse specialist has been appointed to support the improvements and outlined the specialist dementia care program at the service including how consumers with severe behavioural and psychological symptoms of dementia are supported.

In relation to wound management, the response indicated the service’s wound management policy has been reviewed with all wound assessments and management plans completed, where required. The response indicated monitoring of wound management and incidents will be undertaken by management and reported to relevant meetings and committees. Education will be provided to staff in relation to skin and wound management.

I note the response includes actions taken in relation to consumers named in the Site Audit report. The Assessment Team recommended this Requirement was non-compliant, however, with consideration to the additional information provided within the Approved Provider’s response, I find this Requirement compliant. I encourage the service to continue to implement actions and improvements as outlined in the PCI.

Requirement 3(3)(b):

The Assessment Team recommended this Requirement was not met. The Assessment Team found the service did not effectively manage high impact risks related to the monitoring and use of medication for changed behaviours, post fall observations, choking and diabetes management. Management identified the service’s high impact and high prevalence risks include falls, weight loss, cognitive impairment, pressure injuries and diabetes.

Consumer documentation related to the management of changed behaviour was not current or comprehensive with risk management strategies not consistently implemented or documented in consumer care plans. Charting of consumer behaviour was not accurate or consistently reviewed to evaluate the effectiveness of interventions. Documentation did not demonstrate staff seek to identify and support unmet consumer needs, potential triggers for changed behaviours or the impact of behaviours on the consumer and others. For consumers subject to chemical restraint, documentation did not demonstrate alternative strategies were used to support changed behaviours in accordance with recommendations from medical professionals and psychotropic medication use was monitored, or their effectiveness assessed.

A review of documentation for a consumer identified as a high fall risk demonstrated referrals to medical and allied health professionals were completed, however, monitoring of neurological observations was not completed post fall. For consumers with swallowing difficulties, consumer documentation detailed allied health referrals, however, did not reflect the related risks with monitoring and charting inconsistently completed. Diabetic management plans were observed for consumers with diabetes; however, appropriate alerts and risk management strategies were not consistently documented. In response to feedback, management advised the service is consulting with the consumer’s medical practitioner in relation to diabetes management.

The service has policies and procedures available to guide staff in the management of high impact and high prevalence risk, however, these documents did not always align with best practice principles or legislation and included incorrect definitions in relation to restrictive practices. Management acknowledged feedback provided by the Assessment Team with plans for remediation included within the service’s PCI.

The Approved Provider’s response indicated the actions of reviewing policies, procedures and documentation related to high impact and high prevalence risks. Guidelines on what constitutes high prevalent risk will be developed with regular analysis of data and recommendations to be provided to the clinical governance committee. A draft high-risk register was implemented and will be used to assist with monitoring restrictive practices in conjunction with the psychotropic register. High risk consumers will be monitored using the register. The response indicated a validated pain assessment tool is available within the service’s electronic management system and is used to populate pain care plans. The response included actions to be taken in response to the high impact and high prevalence risks of pain, choking, falls and diabetes which included undertaking audits, assessments, creating alerts for staff, reviewing documentation to ensure follow up actions are completed and creating individualised care plans. A training plan has been developed and staff education will be completed. I note the response includes actions taken in relation to consumers named in the Site Audit report.

I acknowledge the Approved Provider’s response and planned actions to address the identified deficits. Given the potential impact where high impact or high prevalence risk have not been considered could be significant, further time is required to ensure all actions are implemented, embedded in practise, and evaluated. I find this Requirement non-compliant.

Compliance with remaining requirements:

Consumers and representatives confirmed staff consult with them about needs, preferences, and goals when consumers are nearing the end of life. Consumer documentation included advance care directives, regular reviews by medical and allied health professionals and discussions regarding consumer wishes. Staff described the knowledge and skills required to provide palliative care services.

A review of consumer documentation demonstrated staff take appropriate action in response to consumer deterioration or changes in consumer health and well-being including referrals to medical professionals. Staff described the process of identifying and responding to change in consumer condition or deterioration. Consumers and representatives reported they were confident the service would respond to change in consumer condition in a timely manner.

Consumers and representatives reported staff understood consumer care needs and changes to care is effectively communicated. Management and staff described how consumer information is shared within the service and with others where responsibility for care is shared through various communication methods. A review of consumer documentation demonstrated communication within the organisation and included reports from external providers of care. The service’s electronic care documentation system has care alerts and task appointments to advise staff of consumer care needs.

Management and staff described the service’s referral processes and provided examples of referrals made and how consumer care documentation is updated following specialist reviews. This was consistent with consumer documentation reviewed which demonstrated timely and appropriate referrals to other providers of care and services when consumers experience a change in their condition. Consumers and representatives were satisfied with the access and referrals to medical, allied health and other health care professionals.

Staff demonstrated an understanding of how to prevent, recognise and minimise the spread of infection and the use of standard precautions. Staff confirmed they have completed training on Infection Prevention and Control (IPC), hand hygiene and the use of Personal Protective Equipment (PPE). A review of consumer documentation demonstrated consumers are vaccinated for influenza and COVID-19 following consent being obtained. The service has a process for screening visitors, contractors, and staff for COVID-19. The service has an IPC lead and outbreak management plan for respiratory and gastrointestinal infections.

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Staff described how the lifestyle program is tailored to consumer needs, ensuring activities are available for all consumers. Consumers and representatives were satisfied with the supports provided to meet their goals and maximise their independence. The service develops a well-being care plan in consultation with each consumer which details consumers’ goals, interests, and preferences. The lifestyle calendar is developed based on consumer preferences and feedback. The Assessment Team observed the lifestyle calendar was displayed throughout the service and consumers were observed to be participating in a range of activities.

Consumers were satisfied their emotional, spiritual, and psychological well-being is supported. Staff described how they support individual consumers’ emotional and spiritual needs including the process followed if changes in consumer mood is identified. The Assessment Team noted consumer lifestyle plans were individualised and included information on emotional, spiritual, and psychological needs.

Consumers reported the service supports them to maintain relationships, participate in the community and in meaningful activities. Staff demonstrated an understanding of individual consumer needs, goals and preferences which was consistent with information included within consumer care plans. The service supports consumers to engage in community groups and activities.

The service has systems to facilitate effective communication within the organisation and with others where responsibility for care is shared. This was consistent with staff feedback who described how they communicate with health professionals involved in consumers’ care. Consumers and representatives were satisfied consumer needs and preferences are effectively communicated within the service and with other services. A review of consumer documentation demonstrated staff have access to current consumer information and communication from allied health professionals is documented.

Staff described processes followed to engage with other organisations and providers of care to meet consumer needs and preferences. Consumers were satisfied with referrals made to other organisations of care. A review of consumer documentation demonstrated referrals to allied health professionals and the involvement of community organisations. Consumer care planning documentation was noted to be updated following health professional reviews.

Consumers were satisfied with the variety, quality and quantity of meals provided. A review of documentation detailed consumer meal choices, dietary requirements, and allergies. The service has recently established a food and dining champions program and has implemented actions to improve the dining experience. The service’s menu is approved by a dietitian and accommodates consumers’ cultural preferences. Staff described the process of checking consumer dietary requirements, supporting consumer choice and creating a pleasant dining experience.

Consumers were satisfied with the condition and cleanliness of equipment provided. Staff described training they have received to ensure equipment is appropriately used. The Assessment Team noted shared equipment was cleaned between use with equipment well maintained and maintenance schedules up to date.

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Consumers and representatives reported the service environment is welcoming and promotes a sense of independence and belonging. Management described how they encourage consumer independence and how the service environment supports wayfinding. The Assessment Team observed consumers socialising in communal areas and signage to support wayfinding.

Consumers were satisfied with the cleanliness of the service environment, reporting it is well maintained and they can move freely both indoors and outdoors. Staff described cleaning regimes and how hazards are managed. A review of documentation showed no outstanding maintenance issues posing risk to consumers with cleaning logs up to date and consistent with staff feedback. The Assessment Team noted the service environment was clean and well maintained.

Staff described the preventative maintenance schedule for furniture and equipment including the process of reporting issues. Consumers and representatives reported furniture, fittings and equipment are clean and well maintained. Documentation reviewed showed maintenance and cleaning schedules and logbooks were up to date. The Assessment Team noted the service had suitable furniture to allow consumers with various mobility needs to socialise in communal areas.

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Consumers and representatives demonstrated an awareness of the service’s feedback process and expressed they were comfortable with raising issues or concerns with the service. The service provides multiple opportunities for consumers, representatives, and staff feedback with information regarding feedback methods displayed in the service environment. Management described, and staff demonstrated an awareness of the process of reviewing and actioning complaints. A review of the service’s feedback register showed active feedback processes from consumers, representatives, and staff. I note the response indicates actions taken in response to a consumer named in the Site Audit report.

Consumers, representatives, and staff were aware of external supports available to assist consumers who wished to lodge a complaint, if needed. A review of information packs provided to new consumers included information on advocacy services. The Assessment Team observed advocacy service posters within the service environment, in several languages.

Management and staff described the complaints handling process including collaborating with consumers and representatives and providing an apology. Most consumers and representatives were satisfied with the process followed to resolve complaints or address feedback provided. A review of feedback and complaints documentation demonstrated complaints are acknowledged and actions taken to rectify the issue. The service has an open disclosure policy.

Management described, and a review of documentation confirmed, improvements implemented as a result of feedback provided by consumers and representatives. This was confirmed by consumers and representatives who said they were satisfied the service uses their feedback to improve. The service has a complaints policy which includes informing improvements, where appropriate.

# 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

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Most staff reported sufficient staffing levels and all staff confirmed they can ask for assistance, if required. Management detailed processes to support effective and efficient staffing and described a board approved project being implemented to review human resource strategies, processes, and role allocations against external benchmarks. The service has a process to monitor call bell response times with this data discussed during meetings. The Assessment Team observed sufficient staffing levels across the service during the Site Audit.

Most consumers and representatives reported staff are kind and caring during interactions. Staff demonstrated an awareness of individual consumer needs and described the service’s culture of treating consumers with respect. Staff were observed to engage with consumers in a respectful and friendly manner during the Site Audit. The organisation has policies and guidance material for staff in relation to duty of care, diversity, and the organisation’s values.

Management described the organisation’s recruitment processes including the verification of qualifications required for each role. The service has an online training system which includes onboarding education and processes to ensure non-regular staff have undertaken orientation and training. Staff were satisfied with career development support provided by the service. The service has policies and guidelines in relation to the recruitment process.

Staff were satisfied with the support they receive to develop their skills and confirmed they participate in training. The service has a mandatory training matrix with staff required to complete training on a range of topics. A review of training records demonstrated most staff were up to date with mandatory training and there was evidence of evaluation of training by participants. The service has position descriptions outlining the requirements, responsibilities, and duties of each role.

A review of performance management records demonstrated processes to track and evaluate the effectiveness of staff performance with most annual performance reviews completed for clinical and care staff. This was consistent with staff feedback which indicated they have completed a performance review in the last year. Management described how formal and informal performance appraisal methods are used to identify, plan and support staff training and development.

# 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirement 8(3)(e) and as a result, does not comply with Standard 8.

Requirement 8(3)(e):

The Assessment Team recommended this Requirement was not met. The Assessment Team found the service did not demonstrate appropriate identification, monitoring, and minimisation of the use of restrictive practices, in particular chemical restraint. BSPs were not individualised and did not detail non-pharmacological strategies to be utilised prior to the use of a restrictive practice or that restrictive practices should be used as a last resort. A review of reports to the board and clinical governance committee included information on restrictive practices, however, did not include relevant metrics. The service has a psychotropic medication register with management responsible for managing restrictive practices.

Staff outlined processes to reduce the risk of infections and have completed IPC training. The service has an antimicrobial stewardship policy and monitors infections and antimicrobial agent prescriptions. Infections and antimicrobial stewardship are reported to the clinical governance committee and board. The service has a process to screen consumers who experience a change condition or behaviour through urine dipstick testing, however, the process was not consistent with best practice.

Staff demonstrated an awareness of open disclosure. The service has a process to ensure staff practice open disclosure when things go wrong. This was confirmed by consumers and representatives who reported they receive an apology when things go wrong. A review of incident documentation showed senior staff inform consumer representatives of adverse events.

Under the heading of Requirement 3(3)(a), the Approved Provider’s response outlined the planned action of implementing a monitoring process to reduce or stop the use of restrictive practices in consultation with medical officers, representatives, and consumers. The response indicated this action is ongoing, however, progress has been undertaken with the use of a draft high-risk register commenced. This register will be used to record and monitor restrictive practices in conjunction with the psychotropic register. As detailed under the heading Requirement 3(3)(b), the response indicates the service will undertake regular analysis of data related to high impact high prevalence risks including the use of medications to manage changed behaviours. The response indicated a report with recommendations will be provided to the clinical governance committee on a bi-monthly basis.

The response indicated the planned actions of reviewing the service’s antimicrobial stewardship policy to ensure antibiotic stewardship is supported by best practice principles and the implementation of the Commission’s Clinical Pathway for Older People in Aged Care Home: Suspected Urinary Tract Infection document. The response indicated the clinical leadership team will review directives and relevant documentation for instruction on urine testing and education will be provided to staff on urine dipstick testing.

I acknowledge the Approved Provider’s response and the planned actions to address identified deficits. However, given the potential risks associated with a lack of adequate clinical oversight in relation to minimising the use of restraint, further time is required to implement and sustain the actions in practise. I find this Requirement noncompliant.

Compliance with remaining requirements:

Consumers and representatives were satisfied with the opportunities provided to engage with the service. Management described processes which support consumer engagement and staff reported that consumer centred care is supported through policies and education. Consumer surveys are conducted annually and as part of the service’s monthly audit program. Documentation reviewed confirmed processes are in place to support consumer engagement.

The organisation’s board has oversight and accountability of the service’s performance and is responsible for ensuring quality care is delivered and appropriate risk management. The board’s membership was recently updated to ensure regulatory requirements are met and clinical, legal, and financial expertise are represented. The board is supported by subcommittees. A review of board meeting minutes demonstrated deficits in relation to reporting restrictive practices to the board and clinical governance committee.

The service demonstrated governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The organisation identified plans to replace or improve several of the service’s systems and processes as it was identified they do not support best practice. These actions were documented in the service’s PCI.

The organisation has electronic systems and processes in place which allows staff to access the information they need to perform their role including organisational information. A review of consumer documentation demonstrated deficits in BSPs and wound assessments. The organisation advised these deficits have been identified, are included in the service’s PCI and a review of all consumer documentation has commenced. The organisation will be implementing a new care documentation system as the current system does not support effective monitoring of consumer care documentation. Management described the service is transitioning to a new policy and procedure system with enhanced links to regulation and best practice guidance. The Assessment Team identified deficits in policy documentation including in relation to restrictive practices. In response to feedback, management advised they will review documentation to ensure alignment with best practice.

The service demonstrated effective financial governance systems to manage resources and financial requirements. In relation to financial management, the board is supported by an audit subcommittee with a monthly report provided to the board. The organisation has a financial delegation policy and guidelines.

The service has policies and procedures to ensure the workforce is skilled, knowledgeable, and clear guidance is provided in relation to responsibilities and accountabilities. Management demonstrated how rostering, recruitment processes, mandatory training requirements and performance reviews are managed and monitored.

Regulatory compliance is monitored at the organisation level with identification and reporting from external sources. Regulatory requirements are communicated to the board, management and staff including when changes to policies and procedures occur. A review of board meeting minutes demonstrated consideration of changes to ensure the organisation demonstrates effective governance processes and meets reporting and other regulatory requirements.

The organisation has a feedback and complaints system to ensure complaints are lodged, responded to, and used to inform the service’s PCI. The number of complaints received are monitored and reported to the board. The organisation is currently implementing several projects to improve services and strengthen the organisation. The service’s PCI confirmed continuous improvements across the service and organisation with a range of feedback sources used to drive improvements.

The organisation has a risk management framework, risk register and incident system with reporting regularly provided to the board. The service has frameworks, policies, and procedures to respond to incidents and support the management of consumer risk including high impact and high prevalence risks. External consultation and audits are undertaken to support the review of systems and risks. Staff confirmed they have received training on the Serious Incident Response Scheme and demonstrated an understanding of their reporting requirements. Management described the service’s processes in relation to supporting consumers to take risks and how incidents and consumer risk are investigated, and actions taken in line with organisational policies and procedures. A review of meeting minutes demonstrated the clinical governance committee does not monitor all risk areas including in relation to restrictive practices. Management advised these deficits have been identified with a draft tool in place to monitor all consumer risk and ensure appropriate actions are taken at the individual and service level. Management advised processes relating to high prevalence risk are being reviewed.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)