Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Halls Creek Peoples Church Frail Aged Hostel |
| Commission ID: | 7178 |
| Address: | 440 Neighbour Street, HALLS CREEK, Western Australia, 6770 |
| Activity type: | Site Audit |
| Activity date: | 7 November 2023 to 9 November 2023 |
| Performance report date: | 6 December 2023 |
| Service included in this assessment: | Provider: 1552 Halls Creek Peoples Church Incorporated  Service: 4706 Halls Creek Peoples Church Frail Aged Hostel |

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 Halls Creek Peoples Church Frail Aged Hostel (**the service**) has been prepared by M Glenn, 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.

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers/representatives, staff, management and others; and
* a performance report dated 27 January 2023 for a site audit undertaken from 29 November 2022 to 1 December 2022.

The provider did not submit a response to the assessment team’s report.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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**

**Requirement (3)(b)** was found non-compliant following a site audit undertaken in November/December 2022 as care and services were not culturally safe. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, employment of a lifestyle coordinator and a lifestyle staff member; commencement of fortnightly visits from grade 5 students from a local school who have been asked to introduce themselves by their skin group, language and country which is the traditional and Kinship way of introduction; and held a day of celebration during NAIDOC week and opened the service to the local community.

**At the site audit, in relation to all requirements in this Standard**, consumers were found to be treated with dignity and respect and their culture valued. The service supports consumers to recognise and respect their cultural identity and feel safe at the service. Consumers have a personal profile developed on entry that identifies their life story, including their ‘land’ and language. Consumers said staff are respectful of them and felt safe living at the service, and staff were observed treating consumers with respect, with some staff speaking to consumers in their own language.

Consumers are supported to make decisions, including relating to risks they may choose to take. The service’s admission pathway includes identification of consumers wishing to take risk activities. Where identified, a dignity of risk care plan and consent form are completed in consultation with consumers and/or representatives which identify risks and interventions to minimise the risk.

Consumers are supported to make decisions regarding who should be involved in their care. Care files included directives provided by consumers regarding substitute decision makers of their choice, and included discussions regarding care and services of consumers under a Public Guardian. Consumers are provided information that is current, accurate and timely, including through access to care plans, meeting forums and one-to one conversations. The service has access to interpretation services for consumers with language difficulties. Some staff were observed talking to consumers in their own language, and other staff were speaking words they had learnt or made gestures to increase consumers’ understanding. Consumers were observed making choices in relation to their everyday activities, such as if they wished to join in activities, the area they wanted to spend time in, and the fruit they wanted for afternoon tea. There are processes to ensure consumers’ privacy is respected and personal information kept confidential.

Based on the assessment team’s report, I find all requirements in Standard 1 Consumer dignity and choice compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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

Assessments are conducted on entry, in line with a clinical admission pathway, and on an ongoing basis to inform the development of comprehensive care plans to guide staff in the provision of care and services. Where risk is identified, discussions are undertaken with the consumer or representative and interventions to minimise or mitigate risks are developed. Consumers and/or representatives have the opportunity to discuss consumers’ care plans at a care meeting, shortly after development.

Care files included advance health directives which guide staff in consumers’ wishes during the terminal stages of life. Palliative care plans are developed when consumers are identified by registered and medical staff as nearing the end of life and include additional care, and emotional and cultural support needs. Clinical staff spend time with the consumer or representative to discuss end of life choices and treatment nearing the end of life, as well as advance health directives and wishes for end of life care.

Care files demonstrated ongoing partnership with the consumer and significant others in assessment, planning and review of care needs. Consumer representatives, including guardians, are involved in consumers’ ongoing care at meetings with the doctor or clinical nurse manager, and referral to other services is undertaken for assessment and clinical support. Staff attend a handover at every shift and information regarding changes in consumers’ conditions are reported.

Consumers’ care and service needs are reviewed regularly, including following incidents or changes in their condition. Care and service needs are monitored through completion of monthly resident of the day processes and six-monthly assessments. Assessments are also conducted in response to incidents or changes in condition. Care files showed ongoing review and assessment by the general practitioner, clinical nurse manager and allied health professionals, with clinical care being changed in line with recommendations.

Based on the assessment team’s report, I find all requirements in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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

**Requirement (3)(g)** was found non-compliant following a site audit undertaken in November/December 2022 as infection related risks were not minimised through implementation of standard and transmission based precautions to prevent and control infections. The assessment team’s report provided evidence of actions taken to address the deficiencies identified, including, but not limited to, appointed an infection prevention and control lead who is currently undertaking the course; employed cleaning staff and additional care and services staff; and updated the outbreak management plan.

**At the site audit, in relation to all requirements in this Standard**, each consumer was found to receive safe and effective care based on assessment and best practice guidelines. Clinical work instructions and clinical pathways are available to guide staff in best practice care. Care files demonstrated effective and appropriate management of skin integrity, wounds, nutrition and hydration, and weights. Care files also demonstrated effective management of high impact or high prevalence risks relating to swallowing, diabetes, falls and psychotropic medications, with appropriate strategies to minimise risk documented. Registered staff review consumers’ care daily to ensure risk of harm is identified, follow up interventions to reduce risk are implemented and referrals to specialist providers initiated, as required. Risk is monitored and reported through monthly reports for further analysis and discussions to identify and implement resources to minimise risk.

Clinical pathways guide staff in palliative care and consumers have an advance health directive completed to direct staff in their wishes when nearing the end of life. Palliative care plans are developed when consumers are identified as nearing the end of life and include consumers’ additional and changed care requirements. Progress notes for a consumer who passed away at the service showed the service discussed the consumer’s care with their family who reported the consumer wished to be comfortable, pain free and remain at the service. The consumer was administered pain relief medication as ordered by the general practitioner and progress notes showed staff followed the consumer’s palliative care plan. Staff said they have training in palliative care and understand consumers have additional and changed needs when they are nearing the end of life.

Care files demonstrated changes to consumers’ health and condition are recognised and appropriately responded to. Registered staff monitor consumers’ health status, liaise with consumers and/or their representatives, and initiate referrals, where required, for medical or allied health review or transfer to hospital. The Yura Yungi Medical Health Service doctors visit the service weekly, or on referral following changes, and care plans are updated to reflect health professional recommendations as required. Other services providers, including the medical team and allied health professionals, have access to consumers’ clinical data and following assessment or review, enter information or recommendations into consumers’ progress notes or assessments. Staff were familiar with consumers’ care needs and described changes made in care.

Standard precautions are used to prevent and minimise infection-related risks, with staff guided by organisational policies and procedures. The service has an infection prevention and control lead, and management described the service’s approach to antimicrobial stewardship. The correct antibiotic infections is prescribed and for the shortest duration of therapy, and is considered in consultation with the general practitioner, clinical staff, consumers and their representatives, where applicable. For three consumers, care files evidenced process of review in relation to urinary tract infections, including collection of specimens, and notifications to the general practitioner for consideration relating to treatment. Infection reports enable the service to monitor and analyse infections as part of the service’s monthly clinical incident analysis review. An influenza outbreak in July 2023 was monitored by the public health service with the health service coordinator noting in the final feedback that the service had excellent management of the outbreak. Staff said they are trained in how infection is spread and understand hand washing is very important.

Based on the assessment team’s report, I find all requirements in Standard 3 Personal care and clinical care compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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

**Requirements (3)(b), (3)(c) and (3)(f)** were found non-compliant following a site audit undertaken in November/December 2022 as services and supports for daily living did not promote each consumers’ emotional, spiritual and psychological well-being, assist them to participate in their community within and outside the organisation’s service environment, or do the things of interest to them; and meals were not varied and of suitable quality. The assessment team’s report provided evidence of actions taken to address the deficiencies identified, including, but not limited to, employment of two staff from the area in the positions of lifestyle coordinator and lifestyle staff; re-introduced Smoking Ceremonies after consumers have passed away at the service; commenced a catholic service each week at the service; supporting consumers to attend the men’s or women’s shed held weekly in the community; commenced a weekly cultural cook-out in the camp oven and barbeques; and completed a full menu review with the dietitian identifying meals consumers enjoyed.

**At the site audit, in relation to all requirements in this Standard**, social activities were found to be planned, and staff spend time with consumers supporting their independence and quality of life. Information relating to consumers’ language, background, country, leisure interests, and spiritual and emotional preferences is gathered through assessment processes and used to develop a service plan to support consumers’ lifestyle, independence and social well-being. Risks related to independence are identified and discussed with the consumer or representatives to enable consumers make lifestyle choices. Diversional therapy daily activity charts for five consumers demonstrated involvement in activities they enjoy, and staff demonstrated an awareness of consumers’ emotional preferences and provided examples of how they support individual consumer’s emotional needs.

Consumers are supported to participate in the community within and outside the service, have personal relationships and do things of interest to them. Care files identify consumers’ past life and interests, as well as supports consumers’ require to undertake activities of their choice. One consumer has recently been supported to return to their community for a week to visit with family and friends, and another consumer is supported to attend the women’s shed and art centre.

Information about consumers’ condition, needs and lifestyle preferences is communicated within the service and with others as required. Consumer information is held in assessments, care plans, progress notes and charts that other services can access through the electronic system. Clinical staff communicate formerly with other services through email or verbally, and staff said they access information relating to consumers’ needs and preferences through care plans, handover processes and from other staff.

Meals provided are varied and of suitable quality and quantity. Meals are cooked fresh each day, in line with a four-weekly rotating menu which has been reviewed by a dietitian. Consumers have morning and afternoon tea with fresh fruit served each afternoon. All consumers interviewed said the food was good.

Equipment used for day-to-day living is safe, suitable, clean and well maintained. Preventative and reactive maintenance processes, supported by external contracted services are in place, as well as cleaning processes. The service bus has undergone servicing to ensure it is safe when transporting consumers. Staff said they have undertaken training in safe manual handling that includes use of lifting equipment, and have access to enough equipment to assist them with consumers’ lifestyle activities.

Based on the assessment team’s report, I find all requirements in Standard 4 Services and supports for daily living compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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

**Requirement (3)(b)** was found non-compliant following a site audit undertaken in November/December 2022 as the service environment was not safe, clean and well maintained. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to; development of a comprehensive cleaning schedule covering all service areas; employment of dedicated full time cleaning staff and a maintenance team; and creation of a comprehensive maintenance schedule.

**At the site audit, in relation to all requirements in this Standard**, consumers said the service is welcoming and the facilities, gardens and central courtyard and activities area are clean and well maintained. All consumers like living at the service, feel safe, and find their rooms and common areas to be relaxing and comfortable. Consumers’ rooms were safely appointed and personalised to their wishes. Aboriginal art is displayed in the reception area which included newly acquired comfortable seating arrangements for consumers and their guests to sit and catch up.

The service environment is safe, clean, well maintained, comfortable and enables consumers to move freely, both indoors and outdoors. The service has dedicated cleaning staff, a fulltime maintenance officer and fulltime gardener. Cleaning, preventative and reactive maintenance processes, supported by external contracted services, are in place, and staff could describe processes for cleaning and submitting maintenance requests. The service maintains close connections with other community services and organisations, including local emergency service personnel, in case of an emergency, and regular visits by local police officers occur to assist with emergency planning and security.

Furniture, fittings and equipment are safe, clean, well maintained, and suitable for consumer use. Consumers said they feel safe when staff use equipment and it was appropriate for their needs, and where there are any issues, maintenance staff are quick to respond. Staff were confident to use equipment and said they had received training on its use.

Based on the assessment team’s report, I find all requirements in Standard 5 Organisation’s service environment compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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

**Requirements (3)(b) and (3)(d)** were found non-compliant following a site audit undertaken in November/December 2022 as consumers were not made aware of and did not have access to advocates, language services and other methods for raising and resolving complaints; and feedback and complaints were not reviewed and used to improve the quality of care and services. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, discussing feedback and complaints processes as a regular agenda item at resident and staff meetings; displaying advocacy information, including in the local language; providing access to native country language services using interpreters and translated feedback process posters and documentation; and development of a service improvement request form.

**At the site audit, in relation to all requirements in this Standard**, consumers understood processes to provide feedback to the service, and said management and staff are responsive to any concerns they raise. Noticeboards displayed feedback and complaints information, including in the Kriol dialect, and feedback forms were available, along with a secure feedback box. Staff said they assist consumers to complete feedback forms when verbal feedback is provided to them.

Information relating to advocacy, internal and external complaints mechanisms and language services is included in the resident handbook and displayed around the service. Staff said they liaise with consumers’ family and friends when consumers have difficulty communicating, and with other Indigenous staff who can interpret an individual’s native language when this is required.

Feedback, complaints and open disclosure policies and procedures are available to guide practice. Management and staff described the service’s complaints management process to gather, address and review feedback, as well as open disclosure principles. A feedback register is maintained and demonstrated complaints are acknowledged, investigations are initiated, and corrective actions taken which are conveyed to the complainant. Consumers confirmed appropriate action is taken to address feedback and complaints and said the service has a transparent approach when things do not go to plan. Organisational reports show complaint and feedback data is monitored, including at an organisational level, to identify trends and areas for improvement. Consumers were satisfied with the way in which management manage and respond to complaints and feedback to improve the quality and care of services.

Based on the assessment team’s report, I find all requirements in Standard 6 Feedback and complaints compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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

**Requirement (3)(a)** was found non-compliant following a site audit undertaken in November/December 2022 as the workforce was not planned, and the number and mix of members of the workforce deployed did not enable, the delivery and management of safe and quality care and services. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, employment of a fulltime lifestyle coordinator and a lifestyle assistant to provide activities to consumers over the seven days of the week; implementation of contingency plans to support therapy activities when lifestyle staff are unavailable; and employment of security personnel to support the safety and reduction of risk to consumers and staff.

**At the site audit, in relation to all requirements in this Standard**, there were adequate staff available to meet the needs of the consumers. Staffing levels are reviewed regularly and staff allocations consider the mix of staff required to deliver culturally safe and quality care, and there are processes to manage staffing shortfalls. Agency staff are regularly used due to the remote location of the service, however, many of same staff return to the service to undertake further contracts, which assists with consistency of care and services. Staff said there were an adequate mix of care staff available to provide care to consumers, and overall, vacant shifts were regularly filled, staff work well as a team, and they can provide feedback to management if they have concerns with staffing levels. All consumers interviewed were satisfied with the level of staff deployed by the service to look after their daily needs, and felt well cared for.

Workforce interactions with consumers were kind, caring and respectful of consumers’ identity, culture and diversity. All staff, including agency staff, were familiar of each consumer’s identity, culture and diversity, and consumers appeared engaged and relaxed when interacting with care staff. Two consumers said the facility manager is approachable, easy to communicate with, and enables them time to discuss their concerns, which has resulted with improvements to their care.

New staff complete a three-month probationary period, buddy shifts and a performance assessment, and management are informed if any issues or gaps in practice are observed and corrective action is taken. Clinical incidents are reviewed and feedback monitored to track staff competency and counselling and additional training is arranged if any issues are identified. Management felt confident that the process of supervision and monitoring they have in place is effective for ensuring staff are competent and that they maintain the required knowledge to effectively carry out their roles. Consumers were confident that staff knew what they were doing.

Staff complete a corporate orientation program which includes mandatory training modules which sets the expectations of care delivery and appropriate behaviour under the Quality Standards. A monthly training schedule is maintained which includes mandatory components, and additional training arranged, where identified, through outcomes of audits, observation of staff practice, staff performance reviews, incidents and feedback. Completion of mandatory training is tracked, and all mandatory training was noted to be completed within the designated period. Staff said they receive the training and education they need to provide safe and effective care.

Regular assessment, monitoring and review of the performance of each staff member occurs. Performance appraisals are conducted formally at three months following commencement with ongoing performance reviews and planning occurring annually thereafter. Performance management processes are initiated following feedback from consumers and staff and where incidents have occurred. Management support staff to improve performance and where the need for improvement, training, or monitoring is identified, this is actioned.

Based on the assessment team’s report, I find all requirements in Standard 7 Human resources compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

Consumers are engaged and supported in the development, delivery and evaluation of care and services, through meeting forums, one-to-one discussions, and feedback processes. Consumers and representatives said management and staff consult with them directly regarding consumers’ likes, dislikes and preferences for care and services, and check in at regular intervals to review the care they receive.

The organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. The service transitioned from the Peoples Church Frail Aged Care Hostel to Yura Yungi Medical Service Aboriginal Corporation in October 2023. Management have been meeting regularly with the new Board during the transition process to discuss improving security, the recent approval to provide funding to renovate consumer rooms, further building improvements, plans for continuous improvement, compliance, operational matters, staffing and financial governance. There are systems to collect and analyse clinical data and identified risks with the information provided to the Board. The Board is aware of current risks and takes appropriate action to rectify these in a timely manner.

Effective organisation wide governance systems, supported by policies and procedures, relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints were demonstrated. There are processes to ensure these areas are monitored and the governing body is aware of and accountable for the delivery of services.

The organisation demonstrated effective risk management systems and practices, including in relation to managing high impact or high prevalence risks, identifying, and responding to consumer abuse and neglect, supporting consumers and managing and preventing incidents, including use of an incident management system. A clinical governance framework is supported by policies and procedures to guide staff practice, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Awareness of organisational policies and procedures relating to clinical governance was further demonstrated through evidence presented in other Standards.

Based on the assessment team’s report, I find all requirements 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)