Performance

Report

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| Name: | Helping Hand Aged Care - Rotary House |
| Commission ID: | 6051 |
| Address: | 49 Buxton Street, NORTH ADELAIDE, South Australia, 5006 |
| Activity type: | Site Audit |
| Activity date: | 9 January 2024 to 12 January 2024 |
| Performance report date: | 15 February 2024 |
| Service included in this assessment: | Provider: 182 Helping Hand Aged Care Inc  Service: 4068 Helping Hand Aged Care - Rotary House |

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 Helping Hand Aged Care - Rotary House (**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 and management; and
* the provider’s response to the assessment team’s report received 8 February 2024. The response includes commentary directly relating to the issues raised in the assessment team’s report, supporting documentation and a plan for continuous improvement.

# 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 | **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

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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

Consumers said staff treat them with dignity and respect and understand important parts of their life, including their identity and background. They said the service respects their culture, beliefs, and values and they are supported to engage in activities relating to their culture. Care files include information about consumers’ identity, diversity and preferences, as well as the top five most important things to know about them as a quick reference for staff. Information relating to each consumer’s cultural background, requirements and preferences is also gathered on entry to ensure appropriate supports are in place. Staff described treating all consumers with respect, maintaining dignity throughout personal care and daily activities, supporting them to maintain routines and acknowledging preferences.

Consumers feel supported to make decisions about their care and believe these are communicated with others involved, and care files reflect consumers’ expression of choice, needs and preferences. Staff described how consumers are actively involved in their care, are supported to make choices and maintain important relationships.

Consumers feel supported to engage in activities they enjoy and which improve their quality of life, even where risk is involved. Where consumers express interest in taking risks, assessments of cognition and ability to participate in the risky activity are undertaken, relevant health practitioners are involved and strategies to mitigate risk documented. Risks are discussed with consumers and/or representatives to mitigate risk and the service respects consumers’ decisions even if it is against advice given.

Consumers said information communicated to them is accurate, timely and helps them make decisions about their care. Information is provided through various avenues, including noticeboards, activity calendars, menus, flyers and newsletters. Staff are aware of communication challenges of individual consumers and described strategies used to ensure effective communication and consumers’ understanding, and to support decision making. There are processes to ensure each consumer’s 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

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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

The Quality Standard is assessed as compliant as all five requirements assessed have been found compliant. The assessment team recommended requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(a)**

The assessment team recommended requirement (3)(a) not met as some consumers were unable to freely enter or exit the service independently due to the locking of entry/exit doors which required a swipe card to bypass. Of the 71 consumers residing at the service not subject to environmental restraint, four had been provided a swipe card allowing access through the front door between 7:00am to 7:00pm and 13 had been identified as environmentally restrained. Swipe cards are inactive between 7.00pm to 7.00am. Management did not consider the exit/entry door system to be an impediment to consumers, as staff members are employed for 24/7 care and consumers are able to ask staff members for assistance if they wish to enter or exit the service. Management did not consider consumers requiring assistance to use the keypad as environmentally restrained unless that consumer was demonstrating behaviours which was not consistent with the service’s policy. Management said they offer a swipe card to consumers on admission, however, do not keep a record of this discussion, and do not classify consumers who refused a swipe card as environmentally restrained. The assessment team’s report highlights two consumers who were unable to exit the service freely and independently and said they had not been offered a swipe card. One consumer said they often exit the service in the morning and the other said they feel supported by staff to exit the service, however, need to ask staff to open the front door for them. Care files for the two consumers show they have not been recognised as subject to an environmental restraint and a restrictive practice assessment, authorisation form or discussion regarding environmental restraint has not been incorporated into their care.

Management acknowledged the assessment team’s findings and during the site audit, implemented a plan for continuous improvement with a range of actions to address the issues raised. Actions included, but were not limited to, increasing swipe card access parameters would to allow 24/7 access; providing all consumers/representatives of consumers not classified as environmentally restrained, a letter advising them that they can apply for a swipe card; on application for a swipe card, undertaking assessment of the consumer for their capacity to safely exit the service and in the event they are not considered safe to do so, will not be provided a swipe card and will be classified as environmentally restrained. Consumers who choose not to apply for a swipe card will also be assessed as environmentally restrained.

I have come to a different finding to the assessment team’s recommendation of not met and find requirement (3)(a) compliant. I acknowledge consumers did not have independent access to exit or enter the service during the hours of 7.00pm to 7.00am. However, there is no evidence demonstrating that any consumers had been impacted by this, and for the two consumers highlighted, despite not having a swipe card, there was no evidence to demonstrate their movements to and from the service had been restricted. One consumer said they often exit the service and the other feels supported to exit the service, albeit with staff assistance. I do not consider the evidence presented demonstrates systemic deficits relating to assessment and planning processes, including of risks.

In coming to my finding, I have placed weight on the provider’s response relating to assessment of environmental restraint, both during and subsequent to the site audit. Management and the provider acknowledged the issues raised, and the assessment team’s report demonstrates immediate actions were taken by the service to address the issues. The provider’s response to the assessment team’s report states where people had potentially been environmentally restrained, this was an unintended consequence of maintaining a safe environment for all people living in the home, including staff, between the hours of 7.00pm and 7.00am. The provider acknowledges staff mistakenly believed the assistance provided to enable people to exit and enter the home afterhours was not environmental restraint. The service is in the process of enhancing the environmental restraint procedure and associated assessments to improve clarity for staff to guide and inform practice and mitigate further risk.

I have also considered evidence in the assessment team’s report demonstrating consumers and representatives feel consumers are safe at the service and the assessment and planning of care is completed with consideration of associated health risks. Care files show assessment and planning is completed with consideration for consumers’ conditions, needs, and preferences. Assessment and planning of care is completed during routine care evaluations, and more frequently when changes occur, with consideration of risks that could affect the consumer’s health and wellbeing, such as falls and weight loss. Best practice risk assessment tools are used to assist with the assessment risks and with risk-mitigation strategies developed.

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

**In relation to all other requirements**, consumers and representatives said the care provided is appropriate to meet consumers’ current conditions, needs and preferences, and they have been provided an opportunity to express end of life care needs and wishes. Care is guided through care planning documentation which is created on entry and reviewed six monthly and when changes occur. Care evaluation processes include consumers and representatives to best identify the required care needs and preferences. End of life care wishes are encouraged to be expressed on entry and when changes occur. When consumers are transition into a palliative state, supports, including frequent check ins, open discussions and access to medical officers, palliative care services, and spiritual care services are initiated.

Consumers and representatives feel involved in the assessment and planning of consumers’ care, and said they are able to choose who is involved in care provision, including medical officers, allied health professionals and family members. Choices consumers make regarding involvement of family members and preferred healthcare providers is respected and documented. Input and recommendations from those the consumer wishes to involve in care is incorporated into care documentation and communicated to staff through handovers and meetings.

Outcomes of assessment and planning are documented in a care plan which is offered to consumers and their representatives and is accessible to staff and other service providers. Staff described how they share and receive information about the outcomes of assessment and planning, including through access to care plans and handover processes, and consumers and representatives confirmed they are contacted during care evaluations and outcomes and changes of care are communicated to them, with care plans offered and available.

Care evaluations and review occurs six monthly and when incidents or changes occur, and progress notes are reviewed each morning to ensure consumers’ care needs are met. Information received from consumers, medical officers, allied health professionals, handover and care documentation is also used to guide assessments and evaluation of care. Consumers and representatives said they are engaged by the service when care is evaluated, and when incidents and changes to consumers’ care needs occur.

Based on the assessment team’s report, I find requirements (3)(b), (3)(c), (3)(d) and (3)(e) 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

Care files demonstrate each consumer receives safe, tailored and effective personal and clinical care, including in relation to skin integrity, restrictive practices, wounds, medications and pain, in line with best practice guidelines. However, storage of medications requiring cold chain management, while consistent with the service’s policies and procedures, was not best practice. Corrective actions to address the issue were developed by management during the site audit. Clinical staff demonstrated an understanding of consumers’ personal and clinical care needs, and described strategies used to ensure these needs are met. Staff said they have access to policies and procedures to guide provision of care and are updated of any changes to these documents.

Systems and processes assist to identify, monitor, and effectively manage high impact or high prevalence risks associated with consumers’ care. Care files include appropriate assessment and strategies to mitigate risks and evidence involvement of medical officers and allied health professionals in assessment and management of consumers’ care, including high impact or high prevalence risks. Staff are knowledgeable of sampled consumers and strategies and interventions to mitigate risk, and consumers and representatives said consumers feel safe and receive care that supports their needs, health and well-being, and are satisfied with management of high impact or high prevalence risks.

Consumers and representatives are invited to discuss consumers’ end of life wishes on entry, during routine care evaluations and when the consumer’s condition changes. Additional providers of care can be arranged to assist with discussions and support, including medical officers, palliative care services and spiritual services. Staff said when providing end of life care, they ensure consumers are kept pain-free and comfortable. For one consumer whose health is declining, staff have increased monitoring of skin checks and assessments due to their reduced mobility and increased risk of pressure injuries, and additional reviews by the medical officer have been occurring. A conversation has been held with the representative, clinical staff and the service’s palliative care nurse to discuss the consumer’s progressive decline and to review the advance care directive.

Care files demonstrate deterioration in a consumer’s condition is identified promptly, and where required, timely referrals to medical officers and/or allied health professionals are initiated. Clinical staff described actions they would take if a consumer showed signs of deterioration or change, including completing indicated assessments, notifying the medical officer and representatives, and checking the consumer’s care documentation for management strategies. There are processes to ensure information about consumers’ condition, needs and preferences is documented and communicated within the service and with others where responsibility for care is shared. Consumers and representatives are satisfied with how consumers’ complex care needs are supported and that consumers’ care needs and preferences are being communicated between staff and with others responsible for providing care.

There are processes to support the minimisation of infection related risks, to monitor infections and promote appropriate antibiotic prescribing and use. The infection prevention control lead and clinical staff described how they apply infection prevention control measures as part of the care provided. Antimicrobials are minimally utilised and are reviewed for appropriateness when prescribed. Policies and procedures provide guidance on infection prevention and control, outbreak management and appropriate prescription and review of antimicrobials. Consumer care files reflect appropriate monitoring and management of infections and symptoms. Consumers and representatives are satisfied with the infection prevention and control measures utilised by the service to prevent infections and outbreaks.

Based on the assessment team’s report, I find all requirements in 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 feel their daily living needs, goals and preferences are supported, and the service aims to optimise their independence, well-being and quality of life. The service caters supports and services to consumers by ensuring activities provided are chosen by the consumers. Consumers described how the service supports their emotional, spiritual and psychological well-being. The service provides a wide range of activities and supports to consumers based on their needs, goals and preferences. Consumers’ are emotionally supported primarily through one-on-one visits with lifestyle, staff and volunteers. To support consumers’ spiritual well-being, the service holds services of various denominations, and individual visits from the Chaplin can be arranged.

Consumers said they are supported and encouraged to participate in activities of their choice within and outside the service, have personal and social relationships, and do things of interest to them. Staff engage with and get to know consumers to understand their needs and help facilitate connections. An activity calendar, developed in consultation with consumers, is maintained and includes activities that they like or suggest. Consumers are encouraged to provide feedback on the activity calendar at monthly meeting forums.

Information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely referrals are initiated. Care staff described how they are kept up to date with consumers’ changing needs and preferences, and consumers feel the service effectively communicates their needs and preferences within the organisation and with others responsible for care.

Consumers are satisfied with the food provided, describing it as of good quality and quantity. Meals are prepared in line with an organisational four week seasonal menu, which has been tailored based on consumer feedback. Consumers can provide feedback on the food at meeting forums and through informal and formal feedback processes.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use, including through preventative and reactive maintenance processes.

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

Consumers and representatives describe consumers as feeling at home at the service and find the environment safe and comfortable, optimising their sense of belonging and independence. Staff said they aim to create a welcoming environment by building a rapport with consumers, assisting them to maintain independence and giving them the ability to voice their needs. The service is easy to navigate, with spacious, bright and clear corridors, allowing consumers to move through the service freely. Outdoor areas are clean, well-maintained and allow easy flow of movement for consumers with mobility aids. Consumer bedrooms are spacious and large enough to accommodate mobility equipment. All bedrooms have their own bathroom enabling consumers to have their own privacy. Consumer rooms are personalised with items they have brought into the service that remind them of their life and history providing the room with a home-like feel.

Consumers and representatives said consumers feel comfortable within the service environment, can freely mobilise and feel the service is clean and well-maintained. Clinical and care staff explained that consumers are free to move to any area of the service they would like, and they assist consumers who require support to move to a new location. Doors to outdoor areas of the service are unlocked during the day allowing the free movement of consumers, and consumers were observed mobilising to lounge areas, going for walks and visiting friends. Cleaning of consumer rooms and communal areas is undertaken in line with a schedule, and reactive and preventative maintenance processes, supported by contracted services are in place. Furniture, fittings and equipment are clean, well-maintained and in good repair. Consumers said equipment is safe, well-maintained and suitable for them. Clinical and care staff described processes used to report hazards and safety issues within the service.

Based on the assessment team’s report, I find all requirements 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 know how to provide feedback and make complaints and feel safe and comfortable to do so. Consumers are supported and encouraged to provide feedback through various avenues, including verbally to staff or management, through meeting forums, feedback forms, surveys, regular care discussions, and electronic feedback kiosks, which consumers and visitors were using to provide feedback during the site audit. Consumer meeting minutes show consumers are asked for feedback about lifestyle activities, staffing and care provided, and show each consumer in attendance is individually asked for feedback.

Consumers are aware of advocacy services that can make complaints on their behalf if required, and consumers from diverse linguistic backgrounds said they feel able and safe to communicate with staff. The service has access to interpreter services which are managed through the lifestyle team, who also provide resources, such as communication boards to support consumers who are from a culturally and/or linguistically diverse backgrounds. Posters, brochures and pamphlets for various advocacy organisations and the Commission are displayed at the entrance of the service, translated into multiple languages. Information about complaints and advocacy, as well as the Charter of Aged Care Rights are detailed in the consumer handbook, admission information pack and residential care service agreement.

All consumers interviewed who had made complaints felt the service appropriately dealt with their complaints and were satisfied with the outcomes. Where complaints are made, they are acknowledged as soon as possible, and the complainant involved to gather further information and discuss a plan for resolution. An open disclosure approach is used with apology and explanation provided, and transparency regarding what has happened. All feedback is entered into a feedback management system which allows for oversight, review and actioning of complaints, and significant trends or issues requiring attention are inputted into the plan for continuous improvement. The system allows for delegation of improvement items to relevant managers and are discussed at management meetings to maintain oversight. Consumers feel they are listened to, and the service has improved due to feedback and complaints made.

Based on the assessment team’s report, I find all requirements in 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 Quality Standard is assessed as compliant as all five requirements assessed have been found compliant. The assessment team recommended requirements (3)(d) and (3)(e) in Standard 7 Human resources not met.

**Requirement (3)(d)**

The assessment team recommended requirement (3)(d) not met as the service could not provide accurate data regarding how many staff were employed by the service and, as such, were unable to provide accurate evidence that staff were complying with mandatory training in line with the service’s policy. An excel spreadsheet for mandatory competency training data included insufficient and incorrect data to evidence that the workforce was compliant with mandatory training. Overdue training was highlighted in red, however, not all overdue training was highlighted. Compliance figures had been manually calculated for the assessment team. The spreadsheet is managed by the organisation’s head office and the database is monitored at site level with staff informed when they are due and/or overdue. Training data showed six staff overdue with aspects of mandatory training since 2021 to 2022. On the final day of the site audit, management provided a continuous improvement activity titled mandatory training compliance with actions outlined to address the data issues identified.

The provider’s response acknowledges minor discrepancies in workforce training data were identified but do not agree with the assessment team’s not met recommendation. The response states the data discrepancy with mandatory training records resulted from the assessment team only including clinical staff in their calculations and not all staff designations. The provider acknowledges limitations with their current system that requires staff to manually check training reports resulting in data inconsistencies. This issue was identified by the organisation in 2023 and an extensive project has commenced to replace ageing IT infrastructure, with a new system currently being implemented across the business.

I have come to a different finding to the assessment team’s recommendation of not met and find requirement (3)(d) compliant. I acknowledge the discrepancies in mandatory training data, however, this does not demonstrate that the workforce is not supported by the organisation to deliver outcomes for consumers in line with these Standards. In coming to my finding, I have considered the findings of compliance, particularly in Standard 2 Ongoing assessment and planning with consumers, Standard 3 Personal care and clinical care, and Standard 4 Services and supports for daily living which demonstrates quality care and service provision, as well as positive feedback from and outcomes for consumers highlighted throughout the assessment team’s report. The organisation has committed to an extensive IT infrastructure project across the business which it is hoped will resolve the issues identified.

In coming to my finding, I have also considered evidence in the assessment team’s report demonstrating consumers are satisfied staff are adequately trained and equipped to do their jobs. All new employees complete an organisational commencement orientation checklist, are assigned a buddy to support them to complete the checklist, and are rostered as supernumerary for their first two shifts. Records are maintained of all internal education and mandatory training offered as part of the annual education schedule. The schedule has flexibility to allow for incidental training identified through feedback and/or audits, to support service improvements and build staff knowledge. Mandatory training is tailored to each staff designation and includes topics, such as infection prevention and control, elder abuse prevention, manual handling, fire and safety, medication safety and restrictive practices. Clinical staff feel they receive adequate training to perform their assigned duties.

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

**Requirement (3)(e)**

The assessment team recommended requirement (3)(e) not met as while workforce performance is monitored through annual mandatory training and performance appraisal compliance, the service could not confirm a compliance figure. The performance appraisal electronic management system and process in place to review and monitor staff performance demonstrated deficits in workforce data with regards to information management of staff registers. One register comprised of an excel spreadsheet with an excel generated summary. The data summary recorded 184 staff and 23 overdue appraisals, however, when manually counted recorded 187 staff and nine overdue appraisals. Management said the service employs 254 staff. Management provided an email from the systems support department, detailing errors identified in the performance appraisal log, requiring a staff member to manually check and amend the data at site level. An amended performance appraisal log recorded 237 staff and 32 overdue appraisals, however, when manually counted it recorded 240 staff and 27 overdue appraisals. Management was adamant all annual staff appraisals due had been completed and said they would create a plan for continuous improvement and seek support from head office to manually audit the data.

The provider does not agree with the assessment team’s recommendation of not met. The provider acknowledges incorrect formulas were identified in the staff appraisal register which were detected by the organisation in December 2023. An updated staff performance appraisal spreadsheet was provided to the assessment team during the site audit. The current compliance rate for staff appraisals is 94.5%, with a total of 13 staff across the two co-located sites overdue for their appraisals. The organisation has purchased a new electronic system which will resolve the data issues.

I have come to a different finding to the assessment team’s recommendation of not met and find requirement (3)(e) compliant. I acknowledge the discrepancies in performance appraisal completion data, however, this on its own does not demonstrate that regular assessment, monitoring and review of staff performance does not occur. In fact, evidence presented in other requirements in this Standard demonstrates care worker practice is overseen, and therefore monitored by registered and enrolled nurses, and feedback and audit data is used to identify staff training opportunities to support service improvements and build staff knowledge.

In coming to my finding, I have also considered evidence in the assessment team’s report demonstrating the performance appraisal process includes staff completing a self-scoring proficiency guide, and meeting with their manager or supervisor to complete the process. During the face-to-face appraisal, discussion notes are recorded on the form covering areas, such as values, goals, timelines, professional development, compliance with mandatory trainings, self-reflection and self-ratings. Staff said they are notified when annual performance appraisals are due, and while two staff could not recall the date of their last appraisal, both indicated it occurred within the past six months and both were satisfied with the outcome.

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

**In relation to requirements (3)(a), (3)(b) and (3)(c)**, consumers feel an adequate number of staff are employed to deliver effective care, staff respond to call bells promptly and their care has never been adversely impacted. The service is co-located with another of the organisation’s services and staff are employed to work across both sites. An electronic rostering system only allows for the selection of appropriately skilled staff for each shift. A roster book is also maintained to support the service with last minute changes to areas staff are allocated to, and any other real-time amendments made to the roster, to facilitate an appropriate staff mix. There are processes to manage planned and unplanned leave. Staff rosters for the fortnight preceding the site audit show an adequate level of staff across the three daily shifts, with a registered nurse rostered within the co-located services. Consumers and representatives feel the workforce interacts with consumers in a kind, caring and respectful way regardless of cultural background. Staff participate in annual mandatory education that supports cultural safety learnings.

Consumers and representatives feel staff know what they are doing. Position descriptions include responsibilities, accountabilities, qualifications, personal attributes, skills, training and experience required for each role. The service carries out the necessary checks required for staff roles, including national police checks and professional registration requirements. Management determine if staff are competent and capable in their role by liaising with human resources, the learning and development team, analysing staff surveys, discussions at the meeting forums and during the annual staff appraisal process. The service employs registered and enrolled nurses to support clinical care and to oversee care workers.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b) and (3)(c) 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 Quality Standard is assessed as compliant as all five requirements assessed have been found compliant. The assessment team recommended requirement (3)(c) in Standard 8 Organisational governance not met.

**Requirement (3)(c)**

Effective governance systems relating to continuous improvement, financial governance, regulatory compliance and feedback and complaints were demonstrated. However, the assessment team found governance systems relating to information management and workforce governance were not effective and recommended requirement (3)(c) not met. The assessment team notes for both information management and workforce governance, there are deficits in electronic information management systems for workforce compliance data. This includes data relating to staff completion of mandatory training and performance appraisals. In relation to workforce governance, collective data registers maintained by the service and head office do not align. For example, the service recorded a staff member with a very common surname, with three very different first names. Training, vaccination and performance appraisal registers, as well as the staff file, each record the staff member’s name differently. While the assessment team found governance systems relating to regulatory compliance were effective, they did highlight consumers requiring staff assistance to exit the service had not been identified as subject to an environmental restrictive practice.

The provider does not agree with the assessment team’s recommendation of not met. The provider states there are systems to maintain, store and share data and referenced their response for requirements (3)(d) and (3)(e) in Standard 7 Human resources, which I have considered. In relation to workforce governance, there were no issues identified with the availability or skill level of staff. In response to variation in staff names, each staff is provided with a unique employee code which enables their accurate identification. In relation to regulatory compliance, the provider references their response for requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, which I have considered in my finding.

I have come to a different finding to the assessment team’s recommendation of not met and find requirement (3)(c) compliant. The evidence presented does not demonstrate systemic deficits relating to information management and workforce governance systems. I have considered the findings of compliance across the eight Quality Standards demonstrates the organisation’s overall governance systems are effective and ensure positive outcomes for consumers are achieved. I have considered the evidence relating to data management in my findings for Standard 7 Human resources requirements (3)(d) and (3)(e). Evidence relating to environmental restrictive practice has been considered in my finding for requirement (3)(a) in Standard 2 ongoing assessment and planning with consumers as I do not consider this evidence demonstrates the organisation is not aware of their obligations relating to restrictive practices.

In coming to my finding, I have also considered evidence in the assessment team’s report relating to information management and workforce governance demonstrating staff are satisfied they have access to information they need, whenever they need it, including consumer care plans and the organisation’s policies and procedures. All staff are aware of where they can find this information. The workforce is overseen and managed through review of staffing rosters, maintaining training and qualification records, performance appraisals and feedback from consumers and staff. Staff files sampled include evidence of qualification records, training records, and performance appraisal records, indicating there are systems to monitor staff performance.

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

**In relation to all other requirements**, consumers were found to be engaged and supported in the development, delivery and evaluation of care, including through meeting forums, surveys, feedback and complaints processes, and daily interactions. A sample of consumer meeting minutes show consumers provide feedback and input on a range of areas, including food, activities, staffing and their care, and actions are taken in response and are documented.

Consumers said they feel safe living at the service, and they receive the care they need. The governing body seeks information from the service about incidents, clinical trends, risks, feedback and regulatory compliance. Information is passed from the service to regional management and executive teams, who provide information to the Board on a regular basis. There are benchmarks the service has to meet and maintain, and if these are not met, this is flagged with the executive teams and the Board, and corrective action is taken. The chief executive officer and members of the Board visit the service regularly to speak to consumers, representatives and staff members about the care and services being provided. Regular audits are also conducted which allows the Board to satisfy itself that the Aged Care Quality Standards are being met.

The organisation demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can 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 requirements (3)(a), (3)(b), (3)(d) and (3)(e) 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)