Performance

Report

**1800 951 822**

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| Name of service: | Hope Vale Aged Hostel |
| Service address: | Corner Thiele & Thuppi Street HOPE VALE QLD 4895 |
| Commission ID: | 5177 |
| Approved provider: | Hope Vale Aboriginal Shire Council |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 November 2022 to 2 November 2022 |
| Performance report date: | 23 November 2022 |

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 Hope Vale Aged Hostel (**the service**) has been prepared by J Earnshaw, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3 Personal care and clinical care** | **Not applicable as not all requirements have been assessed** |
| **Standard 7 Human resources** | **Not applicable as not all requirements have been assessed** |
| **Standard 8 Organisational governance** | **Not applicable as not all requirements have been assessed** |

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 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 |

Findings

The service was able to demonstrate that assessment and planning identified potential risks to consumers’ health and wellbeing, which included consumers who choose to take personal risks and to ensure consumers receive safe and effective care.

Review of consumer care planning documentation identified assessment and planning included the consideration of risk and reflected the consumer’s current needs, goals and preferences, including consideration of individual consumers’ risks including smoking independently. Consumers’ care and services were reviewed for effectiveness, including when circumstances changed or when incidents occurred.

Staff demonstrated knowledge of the care and service needs for individual consumers and described how information on consumer changes are communicated during handover.

Actions were taken by the service to address Non-compliance in these Requirements following a Site Audit conducted 12 October 2021 to 14 October 2021. Improvements include:

The service has implemented and completed risk assessments and reviewed consumers where deficits were identified in the previous Site Audit.

The service has implemented a suite of assessment tools including:

* A smoking assessment is now included in the admission pack and completed for consumers who choose to smoke.
* A restrictive practice assessment and authorisation form has been developed and implemented for all consumers where restrictive practice is identified and implemented.
* Behaviour support plans have been implemented for Consumers subject to restrictive practises and identifies individualised strategies, personalised interventions, consultation with consumer and representatives, other health professionals and evidence of regular review and monitoring.
* Informed risk has been discussed with consumers and representatives and documented for consumers who smoke, have swallowing difficulties and where restrictive practice is in place.

In coming to my decision of compliance with this requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| 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

The service demonstrated effective infection control practices and preparedness to support the management and prevention of a potential COVID-19 outbreak.

The service created a single point of entry, implemented an entry screening process, prepared an outbreak management kit and provided education to the wider community about public health directions through the local radio station to prevent a COVID-19 outbreak.

Staff interviewed had a shared understanding of the COVID-19 entry screening process, what to do in an outbreak and the infection control measures implemented by the service including hand hygiene, donning/doffing and antimicrobial stewardship.

The service has implemented improvements following the non-compliance identified in the Site Audit conducted 12 October 2021 to 14 October 2021, including a range of infection control measures, including installing hand sanitising stations, monitoring visitor vaccination status, single point of entry to the service with intercom access and screening conducted prior to entry. The service demonstrated adequate supplies of personal protective equipment.

The service has a qualified Infection prevention control lead and organisational policy and procedures have been updated including antimicrobial stewardship and minimising infection risks.

In coming to my decision of compliance with this requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service demonstrated that the workforce has received training in relation to changes in legislation and key areas relevant to their roles and responsibilities. Staff members interviewed confirmed they feel supported, equipped and trained to deliver the outcomes required by the Quality Standards.

Consumer interview reported staff are qualified and have the knowledge and skills to provide safe and quality care and services that meet consumers’ needs and preferences.

Staff were able to describe the training, support, professional development and supervision they receive, and staff confirmed they can raise requests for further training and education which is supported by management. A care staff member described how management has supported them to undertake training as an enrolled nurse by funding their accommodation and flights to Townsville and facilitating placement in Cairns.

The service has implemented improvements following the non-compliance identified in the Site Audit conducted 12 October 2021 to 14 October 2021; including:

The service has conducted staff training including in regards to legislative changes, the updated policies and procedures, the incident management system and escalating of, and the reporting of incidents in the electronic system.

Management has attended external COVID-19 training webinars and provided a factsheet regarding open disclosure and antimicrobial stewardship to staff.

Review of training records confirmed all staff have completed the services’ mandatory training program, which includes the Quality Standards, the Serious Incident Response Scheme, and restrictive practices.

The service has planned the purchase of two additional computers to support staff to complete the electronic training modules.

In coming to my decision of compliance with this requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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 service demonstrated a Board, that is informed, promotes a culture of safe, inclusive and quality care; and effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The service demonstrated the implementation of an effective clinical governance framework and associated risk and incident management systems and practices.

The service was able to demonstrate effective clinical governance systems and processes in place that supported the delivery of safe and quality clinical care.

Actions were taken by the service to address Non-compliance in these Requirements following a Site Audit conducted 12 October 2021 to 14 October 2021. Improvements include:

* **In relation requirement 8(3)(b)**

The service has implemented monthly reporting by management to the CEO, Mayor and Council to ensure the board is informed of clinical indicator data relating to risks, falls, incidents; and engaged in incident analysis, trending and reporting.

Staff demonstrated an understanding of incident management and reporting.

The service has approved and implemented a suite of policies and procedures sourced from an industry peak body, tailored to the service and are conducting monthly training for staff to ensure that it is understood and applied.

The service engaged a specialist aged care consultant to provide advice and updating of the service’s Plan for Continuous Improvement and improved organisational governance systems.

In coming to my decision of compliance with this Requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is Compliant.

* **In relation requirement 8(3)(c**)

The service, management and staff demonstrated that systems and processes were in place providing organisational wide governance relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

**Information Management:**

Staff could readily access the information they needed to deliver safe and quality care and services, and to support them to undertake their respective roles. The service maintained an electronic care management system which provided staff access to consumer care planning and clinical documentation, and an organisation electronic training system enabled staff to complete online training modules. Staff provided verbal handovers to registered and care staff at the beginning of each shift and handover notes were available for staff to refer to.

**Continuous Improvement:**

The service’s Plan for continuous improvement demonstrated, continuous improvement processes occurred and were monitored to improve the quality and safety of the care and services provided to consumers. Continuous improvement initiatives were drawn from a variety of sources, including consumer and representative feedback and complaints mechanisms, regular analysis of clinical and incident data, and internal audits.

Management described the process for implementing and reviewing the improvement initiatives outlined in the service’s Plan for continuous improvement. The service’s Plan for continuous improvement identified the planned and completed improvement actions in relation to various areas of care and service delivery. All staff have received education and training on serious incident response scheme, behaviour support plans, escalation of concerns and incident reporting.

**Financial Governance:**

Management demonstrated additional expenditure by the service to support the needs of consumers, including the purchase of new equipment, building works and infection control related initiatives.

**Workforce governance, including the assignment of clear responsibilities and accountabilities:**

The service demonstrated systems were in place to monitor workforce competency to ensure the workforce was appropriately planned to facilitate the delivery of safe and effective consumer care. Policies and procedures described role responsibilities and accountability.

The workforce was planned, and the number and mix of members of the workforce enabled the delivery and management of safe and quality care and services. Ongoing training for staff was provided in the Quality, open disclosure and incident management has been provided.

Monthly meetings were held, and minutes confirmed management reported on and reviewed clinical indicators, incidents and complaints and reports were escalated to the organisation’s Chief executive officer and Board.

**Regulatory compliance:**

The organisation had a clinical governance policy and monitored changes to legislative requirements through correspondence received from national peak bodies, external agencies and regulatory bodies, such as the Commission and the Public Health Unit. Staff stated, and review of training records demonstrated, staff received training on the Quality Standards, restrictive practices, incident management and the Serious incident response scheme.

**Feedback and complaints:**

The service demonstrated systems and processes in relation to consumer feedback and complaints and staff demonstrated a shared understanding of open disclosure.

In coming to my decision of compliance with this requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is Compliant.

* **In relation requirement 8(3)(d)** the service demonstrated effective risk management systems and processes including current policies and procedures and staff training in incident management and serious incident reporting.

The service has implemented a suite of organisational policies and procedures and provided training to staff related to the new policies and procedures and updated mandatory annual staff training to include serious incident reporting and the incident management system.

The service has implemented an electronic risk management register, and included strategies to manage risks, training provided to staff related to risks, amendments to the environment to mitigate risk and evidenced involvement from other health care professionals.

Incident management reports and clinical indicators are reported and managed via an electronic system and include high impact high prevalence risks. Management reports to the governing board monthly and the electronic system is shared with the Board to enable oversight and updating of the plan for continuous improvement as necessary.

A specialist aged care consultant, engaged by the service, provided guidance to the service in relation to identified noncompliance.

In coming to my decision of compliance with this Requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is Compliant.

* **In relation requirement 8(3)(e),** the service demonstrated an effective clinical governance framework which included:

The service had a suite of policies and procedures available to staff and provided ongoing, monthly training for staff including antimicrobial stewardship, minimising the use of restraint and open disclosure.

Workplace competencies for staff were current, monitored and recorded by the service.

Staff advised they have received training in and demonstrated a shared understanding of antimicrobial stewardship, the incident management system, the serious incident response scheme, restrictive practices and open disclosure.

Staff demonstrated knowledge and understanding of specific care and service requirements and preferences of all consumers living at the service.

In coming to my decision of compliance with this requirement, I have considered the information included in the Assessment Contact - Site report under this and other requirements; and the compliance history of the service. Therefore, it is my decision this requirement is Compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)