**Performance**

**Report**

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| Name: | Ingham Parent Support Group |
| Commission ID: | 700999 |
| Address: | 5 Palm Terrace, INGHAM, Queensland, 4850 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 19 June 2024 to 20 June 2024 |
| Performance report date: | 8 August 2024 |

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.

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 9543 Ingham Parents Support Group Inc  
Service: 27345 Ingham Parents Support Group Inc t/a Ingham Disability Support Service

**This performance report**

This performance report for Ingham Parent Support Group (**the service**) has been prepared by J. Bayldon, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 18 July 2024.

# Assessment summary for Home Care Packages (HCP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Applicable as not fully assessed** |
| **Standard 7** Human resources | **Not Applicable as not fully assessed** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

* Requirement 2(3)(a) – Ensure that all consumers care documentation includes assessment and planning outcomes and consideration of risks to guide staff in the delivery of safe and effective care and services.
* Requirement 2(3)(b) – Ensure that assessment and planning include end of life planning discussions and that these are documented along with the needs, goals, and preference of consumers and that they are addressed within the care documentation.
* Requirement 2(3)(e) – Ensure that consumer care documentation is being reviewed regularly and as circumstances change.
* Requirement 3(3)(g) – Ensure that policies and procedures in relation to antibiotic prescribing have been embedded at the service level.
* Requirement 8(3)(c) – Ensure that the service has effective organisation wide governance systems relating to information management and workforce governance.
* Requirement 8(3)(d) – Ensure that policies and procedures in relation to the effective management of risk and use of risk management systems has been embedded at the service level.
* Requirement 8(3)(e) – Ensure that the clinical governance framework adopted by the service is successfully embedded at the service level and staff are adequately trained in antimicrobial stewardship and minimising the use of restraint.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Not 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. | Not Compliant |

Findings

Requirement 2(3)(a)

Requirement 2(3)(a) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to evidence that assessment and planning considered risks to new and existing consumers and staff had not had training in relevant assessment procedures and tools.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* The Assessment Team reviewed several consumer care plans which failed to evidence assessment and planning processes are being consistently completed, risks to consumers were not identified consistently using assessment tools and strategies are not included in care documentation to guide staff in the delivery of safe and effective care and services.
* Management advised that all consumers were due to undergo falls risk assessments as part of the new care planning process, however these have not yet been completed.
* Management identified several consumers who are at a high risk of falling and have experienced recent falls. A review of identified consumers’ care documentation by the Assessment Team evidenced no mobility or falls prevention information or assessments was included in care documentation.
* Management provided evidence of draft care planning documentation including validated risk assessment tools they plan to implement for all consumers by the end of 2024.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided its plan for continuous improvement (PCI) which detailed the following planned actions:
  + New initial intake, risk assessment, clinical forms, clinical assessment tools and care plan have been finalised and are being implemented.
  + New forms are in progress of being completed for existing clients, with priority given to high risk and level 3 & 4 clients, however the planned completion date of this action is 30 December 2024.

Based on the information summarised above, it is evident that the service has not yet had enough time to ensure that assessment and planning processes are being used for all consumers and that risks are being identified using assessment tools to ensure the delivery of safe and quality care. I am encouraged by the actions the service has identified it is taking as evidenced in the PCI, however the service needs to more time and to prioritise the updating of assessment and planning documentation for consumers to ensure safe and effective care and services are being delivered. Therefore, I find the provider in relation to the service, non-compliant with Requirement 2(3)(a) at the time of the performance report decision.

Requirement 2(3)(b)

Requirement 2(3)(b) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that assessment and planning effectively captured consumer needs, goals and preferences, and discussions around end-of-life planning and preferences were not being offered to consumers.

At the time of the Assessment Contact – Site, the Assessment Team found the following information relevant to my finding:

* All consumers care documentation reviewed by the Assessment Team did not contain any information in relation to end-of-life planning or discussions with consumers were not documented. Management confirmed when interviewed that this does not always occur. Consumers interviewed confirmed they had not had a conversation with the service in relation to end of life preferences. Staff confirmed there is no formal process to guide them in end-of-life preference conversations with consumers.
* A review of care documentation evidenced generic consumer goals and did not include strategies on how the service will address the achieving of these goals.
* Management advised that it had commenced redeveloping care plans and they advised they plan to have this process fully implemented by the end of 2024. Management provided draft care planning documentation to the Assessment Team that evidenced more detail to ensure that consumer needs, goals and preference are captured.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided its plan for continuous improvement (PCI) which detailed the following planned actions:
  + New initial intake document developed (not evidenced) that includes a section dedicated to end-of-life planning and further detail to ensure client needs, goals and preferences are able to be documented.
  + New forms are in progress of being completed for existing clients, with priority given to high risk and level 3 & 4 clients, however the planned completion date of this action is 30 December 2024.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. It is evident from the information summarised above that the service has not had time to embed its updated forms and practices as noted in the PCI. Therefore, I find the provider in relation to the service, non-compliant with Requirement 2(3)(b) at the time of the performance report decision.

Requirement 2(3)(e)

Requirement 2(3)(e) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that the service was conducting reviews of care plans for consumers who have recently experienced deterioration to determine any changes to their assessed needs.

At the time of the Assessment Contact – Site, the Assessment Team found the following information relevant to my finding:

* The services PCI includes actions to have completed all consumer care plan reviews to ensure information and current and complete by 5 August 2024. At the time of the assessment, this had not been completed.
* Management was not able to describe an effective process for ensuring care plans are reviewed annually as per the service’s policies and procedures.
* Consumers interviewed could provide examples of falls that had occurred where there was no mobility or falls risk assessments or strategies to minimise risk of future occurrences in their care documentation. This was also evidenced for consumers with wounds.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of an updated PCI which evidenced the following:
  + Under 2(3)(e) of the PCI:
    - the review of progress notes and ensuring changes are documented in assessments and care plan is ‘ongoing’ with no end date.
    - Education was provided to all care staff reminding them that care plans should be evaluated as changes occur and that the Service Delivery Manager will direct this process.
* The service stated, with no evidence provided, that it had introduced a care plan review template and reviewed the care plan review policy and procedure and they have created a spreadsheet to track and highlight upcoming care plan reviews.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Whilst I acknowledge that the service has provided staff with training in relation to ensuring consumers assessments and plans are updated as things change, I am concerned that the consumer care plans have not all been reviewed and updated regularly based on the services PCI that was evidenced in response to the Assessment Team’s Report. Therefore, I find the provider in relation to the service, non-compliant with Requirement 2(3)(e) at the time of the performance report decision.

# Standard 3

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| Personal care and clinical care | | HCP |
| 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)(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)(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. | Not Compliant |

Findings

Requirement 3(3)(a)

Requirement 3(3)(a) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that consumers were being provided with clinical care in accordance with their care requirements and care staff were not equipped in organisational procedures or care and service requirements for the deliver of care to consumers.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Consumers/representatives interviewed were satisfied with the clinical care they were being provided by the service.
* Care documentation evidenced for consumers sampled that complex care needs such as wound care, pain management, and personal care were being provided by consumers in line with best practice and appropriate to their care needs.
* Staff were able to provide consumer examples where safe and effective clinical care was being provided to consumers.
* The service has commenced daily reviews of consumer progress notes to identify any possible clinical deterioration or concerns that may not have been raised by care staff.
* Training has been given to all staff members and is on-going in relation to various areas of care and service delivery.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service is now ensuring that consumers are getting safe and effective personal and clinical care, and that staff are equipped and able to demonstrate clinical and personal care that is best practice for consumers. Therefore, I find the provider in relation to the service, compliant with Requirement 3(3)(a) at the time of the performance report decision.

Requirement 3(3)(b)

Requirement 3(3)(b) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that it was effectively managing high impact of high prevalence risks for consumers using risk assessment tools and ensuring staff are trained and equipped in their use and risk management practices.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Consumers/representatives considered consumers’ risks to be well managed by the service.
* Care documentation evidenced for consumers sampled that risk prevention strategies were in place and progress notes evidenced engagement by the service with allied health providers to ensure multidisciplinary approach to risk management for consumers.
* Care staff interviewed confirmed and were able to demonstrate they were familiar with the process of identification and escalation of consumers with new or changing risks.
* Staff advised that the service had and was continuing to consistently review all consumer care documentation to ensure correct capture and assessments of risks were identified for consumers and effective management strategies were in place for each consumer with identified risks.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service is effectively managing high prevalence and high impact risks for consumers. Whilst the service has acknowledged that it is continuing to update and review care documentation for consumers, as noted in Requirement 2(3)(a) of this report, I am satisfied that the service has implemented training, assessment tools and strategies to support staff in the effective management of risks for consumers. Therefore, I find the provider in relation to the service, compliant with Requirement 3(3)(b) at the time of the performance report decision.

Requirement 3(3)(e)

Requirement 3(3)(e) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that information pertaining to consumers’ condition is being consistently reported documented or shared within the organisation and that effective strategies to ensure information is communicated are in place.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Management said and a review of documentation confirmed the service liaises with other organisations where care is shared, and evidence provided to the Assessment Team showed improved communication processes had been implemented and were being followed for communication of information within the organisation.
* The service has implemented regular staff meetings to discuss consumers of concern, process and procedure updates and general information sharing.
* Progress notes are now reviewed daily by management and tracked monthly to monitor consistency, and this was evidenced through documentation reviewed by the Assessment Team. Management also advised they are providing staff with support and toolbox talks on ensuring progress notes are of quality.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has taken sufficient actions to ensure that it has remediated the gaps identified in the previous performance report. Whilst the service has acknowledged that it is continuing to update and review care documentation for consumers, as noted in Requirement 2(3)(a) of this report, I am satisfied that the service has implemented communication strategies to support the sharing of information within the organisation in relation to consumers’ needs, goals, and preferences. Therefore, I find the provider in relation to the service, compliant with Requirement 3(3)(e) at the time of the performance report decision.

Requirement 3(3)(g)

Requirement 3(3)(g) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that it had sufficiently updated and implemented its policies and procedures in relation to promoting appropriate antibiotic prescribing and reduce the risk of increasing resistance to antibiotics.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* The service has engaged and external organisation to design and develop policies and procedures pertaining to antimicrobial stewardship and appropriate antibiotic prescriptions. These policies are still in draft and have not yet been implemented for staff usage.
* While some staff were familiar with the concept of antimicrobial stewardship, many staff did not understand what this meant for them in a practical way. Management advised they are currently procuring training surrounding antimicrobial stewardship for staff.
* Implementation of clinical medication form, to be completed by support workers and provided to management in the event a consumer’s medication is identified to have changed.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of an updated PCI which evidenced the following:
  + Policies and procedures had been completed and training had also been undertaken by staff in July 2024 and will continue to be revisited by the service on an ongoing basis.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service sufficiently updated and introduced the policies and procedures in relation to antibiotic prescribing, however I am not satisfied that it has been successfully embedded as the service in its response did not provide any evidence to support this. Therefore, I find the provider in relation to the service, non-compliant with Requirement 3(3)(g) at the time of the performance report decision.

# Standard 4

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| Services and supports for daily living | | HCP |
| 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 |

Findings

Requirement 4(3)(d)

Requirement 4(3)(d) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that information pertaining to consumers’ condition is being consistently reported documented or shared within the organisation and others where care is shared.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Staff confirmed information pertaining to consumers’ condition is shared via the organisation’s administration team.
* Management advised consumer information regarding dietary preferences and requirements is captured and shared with others where care and services are provided including external meal providers.
* The Assessment Team reviewed consumer files which indicated that shift notes are being recorded for the purposes of sharing within the organisation.
* Management has stated that information is shared among office administration staff, and roles and responsibilities are assigned to ensure uninterrupted consumer care and services.
* The service has provided training to all staff on progress note recording and the use of the electronic care management system (ECMS). Additional access to consumer documentation such as referrals and allied health reviews has been provided to all staff.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has taken sufficient actions to ensure that it has remediated the gaps identified in the previous performance report. Whilst the service has acknowledged that it is continuing to update and review care documentation for consumers, as noted in Requirement 2(3)(a) of this report, I am satisfied that the service has processes in place to effectively share information about a consumers’ condition, needs, and preferences within the organisation and with others where care is shared. Therefore, I find the provider in relation to the service, compliant with Requirement 4(3)(d) at the time of the performance report decision.

# Standard 7

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

Findings

Requirement 7(3)(d)

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate that management and staff have been trained in topics such as SIRS and antimicrobial stewardship and the service was not supporting staff in training or policies and procedures to enable them to deliver the outcomes required by these standards.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Management advised they maintain an electronic training system which tracks staff compliance with mandatory modules and contains additional optional training should a deficiency be identified.
* Staff members were able to describe the training, support, professional development, and supervision they receive during orientation and on an ongoing basis. Management advised, and staff confirmed that additional training is provided upon request or when identified during the quarterly performance appraisal processes.
* Management advised mandatory training topics include but are not limited to culturally inclusive care, introduction to Serious Incident Response Scheme (SIRS), restrictive practises, the Quality Standards and dementia.
* A review of the training matrix demonstrates that 40% of staff have completed all mandatory training modules. Currently, the service does not maintain enforcement of mandatory training including deadlines for unfinished training. The service has committed to all mandatory training being completed by 1 August 2024.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has taken sufficient actions to ensure that staff are now being trained and are equipped and supported to deliver the outcomes as required by these standards. I have also taken into consideration that training for staff is ongoing and some staff may not have completed all training, however, I am satisfied the service has procedures in place for tracking training and ensuring staff complete mandatory training. Therefore, I find the provider in relation to the service, compliant with Requirement 7(3)(d) at the time of the performance report decision.

# Standard 8

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| Organisational governance | | HCP |
| 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. | Not 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. | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not Compliant |

Findings

Requirement 8(3)(b)

Requirement 8(3)(b) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to evidence oversight and accountability of the delivery or care and services and the service didn’t have an effective structure to communicate trends or other service level information with the Board to ensure accountability to service delivery.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* The service maintains a Quality Care Advisory Committee which includes quality assurance, clinical staff, and 3 consumer advocates who provide consumer advocacy and quality improvement suggestions.
* Implementation of a management committee meeting with standing agenda items including opportunities for service improvements, complaints, incidents, clinical care delivery, feedback, and performance against the Quality Standards.
* Toolbox meeting minutes evidenced management, clinical staff and coordinators meet regularly to review the service’s performance and this information is shared with the Board monthly.
* Incidents and feedback are managed at the service level and reported to the governing body through monthly formal updates.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has addressed the gaps outlined in the previous performance report and now has the structures in place to be accountable for the delivery of safe, inclusive, and quality care and services for consumers. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(b) at the time of the performance report decision.

Requirement 8(3)(c)

Requirement 8(3)(c) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate effective organisation governance systems in relation to information management, workforce governance and regulatory compliance.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* While the service demonstrated it is effectively communicating relevant consumer information within the organisation and externally where responsibility for care is shared, the service does not have an effective overarching information management protocol. Management said all information relevant to consumer conditions, needs and preferences that is known by organisational staff members will be included in the implementation of updated care plans.
* The service did not maintain a structured workforce governance system which identified responsibilities, and accountabilities in relation to SIRS management, antimicrobial stewardship and workforce code of conduct.
* The service did not evidence effective governance systems pertaining to their regulatory responsibilities under the SIRS. Interviews with staff evidenced inconsistent knowledge surrounding what constitutes a SIRS and their relevant reportable parameters. Management advised there is no specific accountability for SIRS reporting.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of an updated PCI which evidenced the following:
  + New suite of onboarding and clinical documents will feed into a comprehensive care plan that is readily updateable and accessible on staff members mobile roster app. Updates will be highlighted and communicated on shift notes.
  + Position descriptions to be updated to include responsibility for SIRS management, antimicrobial stewardship and workforce code of conduct with a planned completion date of 30 August 2024.
  + SIRS training has been implemented for all aged care staff as well as code of conduct and aged care quality standards. Training to be ongoing at staff meetings to ensure continuity.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has addressed the gaps in relation to regulatory compliance with staff being trained in SIRS and supported in reporting practices by the service. In relation to information management and workforce governance, I am not satisfied that the service has embedded updates to consumer care plans to ensure oversight of consumer information is effectively managed and the embedding of updated position descriptions and responsibilities has not yet been completed at the time of the performance report decision. Therefore, I find the provider in relation to the service, non-compliant with Requirement 8(3)(c) at the time of the performance report decision in relation to workforce governance and information management.

Requirement 8(3)(d)

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service was unable to demonstrate the following:

* Effective processes for identifying and managing high-impact or high-prevalence risks.
* Policies or procedures that comply with the regulatory requirements under SIRS legislation.
* Incidents are investigated and reviewed to identify relevant risks and minimisation strategies.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Management advised the service is in the process of procuring policies, procedures and protocols to guide staff in identifying and responding to incidents. These policies and procedures and still in draft format and have not yet been endorsed by the organisations governing body for implementation.
* Monthly clinical meetings have been introduced to assist in the trending and analysis of clinical data and to discuss incidents and relevant consumer information.
* Interviews with care staff identified inconsistent knowledge on what constitutes an incident, with most staff advising any concerns will be documented in progress notes or reported to the administration team.
* Management advised there is no sole responsibility for the management of incidents as they do not frequently occur. Management stated investigations and follow up are completed on an ad-hoc basis by the ‘relevant’ personnel.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of an updated PCI which evidenced the following:
  + Policies and procedures around SIRS, Care planning, Antimicrobial Stewardship, Behaviour Management, Continence, Delerium, Medication, Nutrition and Hydration, Pain, Personal Care, Wounds, Falls and other administrative procedures are now in use and have been given to staff at meetings held. Training has also been completed for these.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, I am not satisfied that the service has had sufficient time to successfully embed the training provided to staff in relation to the new policies and procedures. An assessment will be required to test that the implementation of the policies and procedures have been embedded at the service level. Therefore, I find the provider in relation to the service, non-compliant with Requirement 8(3)(d) at the time of the performance report decision.

Requirement 8(3)(e)

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken from 30 October 2023 to 2 November 2023 as the service did not have a clinical governance framework that identified the roles and responsibilities of staff in relation to antimicrobial stewardship, minimising the use of restraint or clinical care.

At the time of the Assessment Contact –Site, the Assessment Team found the following relevant information to my finding:

* Management confirmed policies and procedures to clearly identify roles, responsibilities, and guide staff in the effective management of antimicrobial stewardship, the use of restrictive practice and overarching clinical governance, are still in the drafting phase and will not be implemented or staff trained until at least 1 July 2024.
* The service has engaged an external company to design and develop policies, procedures and protocols pertaining to clinical governance and antimicrobial stewardship. These policies are still in draft and have not yet been implemented for staff usage.
* While some staff were familiar with the concept of antimicrobial stewardship, many staff did not understand what this meant for them in a practical way.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of an updated PCI which evidenced the following:
  + Policies and procedures around SIRS, Care planning, Antimicrobial Stewardship, Behaviour Management, Continence, Delerium, Medication, Nutrition and Hydration, Pain, Personal Care, Wounds, Falls and other administrative procedures are now in use and have been given to staff at meetings held. Training has also been completed for these.
  + Staff have had specific training in relation to the use of restraint and restrictive practices

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, I am not satisfied that the service has had sufficient time to successfully embed the training provided to staff in relation to the new policies and procedures and in relation to the use of restrictive practices. An assessment will be required to test that the implementation of the policies and procedures have been embedded at the service level. Therefore, I find the provider in relation to the service, non-compliant with Requirement 8(3)(e) at the time of the performance report decision.

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