Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Joseph Banks Aged Care Facility |
| Commission ID: | 7106 |
| Address: | 58 Canna Drive, CANNING VALE, Western Australia, 6155 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 16 July 2024 |
| Performance report date: | 13 August 2024 |
| Service included in this assessment: | Provider: 63 Retirees WA (Inc)  Service: 4634 Joseph Banks Aged Care Facility |

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 Joseph Banks Aged Care Facility (**the service**) has been prepared by G Tonarelli, 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; and
* the provider’s response to the Assessment Team’s report received 5 August 2024 and 12 August 2028. The response addresses deficits identified in the Assessment Team’s report and included supporting documentation.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not fully assessed |
| **Standard 8** Organisational governance | **Not fully assessed** |

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.

* The provider should continue to progress improvement initiatives regarding updating its policies and procedures and transitioning them to electronic format. The provider should ensure actions implemented are monitored for effectiveness.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Consumers and representatives are satisfied risks relating to consumers’ care is managed effectively and said staff provide care which is safe and aligns with their needs. Representatives are satisfied with the service’s approach to managing their consumer’s risk and gave examples of strategies implemented to manage them. Staff articulated the main risks for sampled consumers, care needs, triggers and strategies to mitigate or prevent harm. Staff also described their use of validated assessment tools and how they identify and escalate risk. Care records showed involvement from clinical persons including allied health professionals relating to high impact, high prevalence (HIHP) risk, and management demonstrated how it monitors, reviews and manages consumers with high risk or complex needs.

Observations, care files and staff interviews confirmed HIHP risks including pressure injuries, changed behaviours and choking are documented with mitigation strategies implemented.

Based on the Assessment Team’s report, I find requirement (3)(b) in Standard 3 Personal care and clinical care compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| 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 |

Findings

In relation to Requirement (3)(c) the Assessment Team found the organisation has an effective governance framework system in relation to continuous improvement and managing feedback and complaints. However, the Assessment Team were not satisfied the organisation had effective governance systems relating to workforce governance and adherence to regulatory compliance:

* the organisation did not ensure all rostered staff were screened and hold an active current national police certificate (NPC). While the organisation demonstrated processes to track and monitor all staff had criminal history screening and hold an NPC, these processes were not effective in preventing staff with expired NCP’s continuing to be rostered on shifts at the service. Documentation confirmed reminders had been sent to staff with expired NCPs, however they were not submitted by staff until a period after they had expired.
* Policies and procedures did not support staff to deliver care in accordance with legislative provisions in relation to security of tenure and criminal history screening. Specifically, the workforce sufficiency and capability policy, whilst directing staff to monitor and track police clearances, did not direct those responsible to remove staff with expired NCPs from the roster, and the security of tenure policy was not in line with legislative guidelines and did not direct staff to deliver effective care.
* During the Assessment Contact, the organisation implemented immediate actions to rectify issues in relation to identified deficits, including improvement actions developed to strengthen the tracking and monitoring processes, and contacting staff with expired NPCs to advise of an immediate ‘N*o clearance, no shift’* policy. The organisation confirmed all policies and procedures are being reviewed for continuous improvement and remain accessible to staff in the interim.

The provider’s response acknowledged the findings and provided commentary to address and resolve the identified deficits. While the provider did not submit a plan for continuous improvement (PCI) on all action items, its commentary did specify the following actions:

* Retraining for staff responsible overseeing regulatory compliance.
* Implementation of information systems including electronic dashboards to monitor and track staff’s regulatory compliance, and trigger notifications where lapses are due to occur.
* Establishing new policies and reviewing and updating existing policies, including those relating to security of tenure and workforce sufficiently and capability, and transitioning them to digital format. Policies and procedures will be updated to include specific directives for responsible staff. Training will be delivered to staff on the digital system to ensure effective utilisation.
* Employment of dedicated staff to oversee staff scheduling inline with the *No clearance, no shift* policy.

In considering the information in the Assessment team’s report and the provider’s response relevant to this Requirement, I am satisfied the provider has sufficient systems in place to identify, monitor and manage workforce governance and regulatory compliance. I acknowledge the evidence brought forward by the Assessment Team at the time of the Assessment contact, however, I have placed weight on improvements initiated by provider to resolve the deficits. For this reason, I come to different finding to the Assessment Team’s recommendation of not met; I find this requirement compliant.

The provider acknowledged all aspects of the Assessment Team’s report and included commentary addressing to the deficits identified as well as supporting documentation. The provider’s response includes continuous improvement actions initiated on the day of or after the Assessment contact to address the deficits including the implementation of electronic dashboards to record, and track, in real-time, staff regulatory compliance and screening requirements.

Documentation included in the provider’s response confirmed relevant policies have been updated to include clear directives for removing staff who do not have active regulatory clearances, and reminder emails sent to staff whose clearances are due to expire in coming months.

In its written response the provider identified that it is undertaking significant work to transition all policies and procedures into digital format to give staff immediate and direct access to up-to-date and relevant information, as well as training in the use of a digital system. While the completion date for these actions are unknown, I recognise the service will need time to make these changes and embed them into staff practice. The provider’s response showed that it prioritised the review of policies identified by the Assessment Team as having urgent deficiencies. For example, a copy of the updated security of tenure policy, and a PCI with completed entries relating to the policy were included in the provider’s response. While information held by the Commission suggests deficits in the policy contributed to ineffective handling of an ex-consumer’s tenure, the evidence included in the provider’s response indicates the organisation has since reviewed and updated its security of tenure policy and procedure to adhere to relevant legislative and user rights provisions.

The organisation demonstrated effective systems to identify opportunities for improvement. Documentation demonstrated various entries relating to all aspects of governance on the organisation’s PCI and staff gave examples of improvements made in response to complaints and feedback.

In relation to Requirement (3)(d), the service demonstrated an effective risk management framework to manage and prevent HIHP associated with the care of consumers and incidents from recurring. The service demonstrated various mechanisms, systems and processes which support its risk management framework, including forums to develop and communicate risk mitigation strategies, reviewing clinical and Serious Incident Report Scheme (SIRS) incident reports for continuous improvement, and a defined dignity of risk policy. Staff are knowledgeable in consumers’ risks and gave examples of how they support consumers to live independently and in a manner that supports their wellbeing and is safe. Staff described their responsibilities to report, document, action and escalate incidents in accordance with the relevant policies.

Based on the Assessment Team’s report, I find Requirements (3)(c) and (3)(d) in Standard 8 Organisational governance compliant.

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)