Performance

Report

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| Name: | Karana |
| Commission ID: | 3482 |
| Address: | 38 Hume Street, YARRAWONGA, Victoria, 3730 |
| Activity type: | Site Audit |
| Activity date: | 17 April 2024 to 19 April 2024 |
| Performance report date: | 24 May 2024 |
| Service included in this assessment: | Provider: 447 Yarrawonga Health  Service: 2233 Karana |

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 Karana (**the service**) has been prepared by P. Wallner, 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 Site Audit 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 15 May 2024.
* Other information held by the Commission.

# 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 | **Not 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 | **Not Compliant** |
| **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 3(3)(a) - Ensure each consumer gets best practice, safe and effective personal and clinical care, including for skin integrity and wound care.
* Requirement 7(3)(d) - Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 8(3)(c) - Ensure there are effective organisation wide governance systems for; information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.

# 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

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements have been assessed as Compliant.

Most consumers and representatives confirmed consumers were treated with dignity and respect, and staff valued their identity, culture, and diversity. One consumer/representative with high care needs reported their dignity was sometimes impacted when staff were busy however the service immediately engaged with the consumer/representative to address their concerns. Staff could articulate how they treated consumers with dignity and respect and showed an understanding of their personal circumstances, life experiences, and cultural backgrounds, which were in line with their care documents. The service had policies and procedures to guide staff conduct in treating consumers with dignity and respect. Staff were observed consistently treating all consumers with dignity and respect.

Consumers and representatives confirmed their cultural identities, beliefs, and practices were recognised, respected, and supported by staff. Staff identified consumers’ unique cultural needs and described how the delivered care and services to meet their cultural needs and preferences. Care documents reflected consumers’ cultural needs and preferences and the organisation had a diversity and social inclusion policy to guide staff practice.

Consumers and representatives confirmed consumers were supported to make decisions regarding their care and services, choose who they wanted to involve in their care, and make and maintain relationships of choice. Management and staff described how they supported consumers to make their own decisions and maintain relationships that were important to them. Care planning documents detailed consumers' choices, needs, and preferences and who they want involved in their care which informs the delivery of care and services.

Consumers and representatives confirmed the service supported consumers to take risks to live the best life they can. Staff provided examples of the risks taken by consumers and described helping them to understand the potential benefits and risks involved in their choices, and consider risk reduction strategies. Care planning documents contained individualised risk assessments, along with informed consent, and agreed risk mitigation strategies. The service had a written dignity of risk procedure to guide staff practice.

Consumers and representatives confirmed they were provided with up-to-date information to inform their decisions about their care and services, through regular care consultations, monthly meetings, monthly newsletters, and activity calendars. Staff described various ways current information was communicated to ensure it was easy to understand by all consumers, including those with cognitive or sensory impairments. Current information was observed to be available to consumers in a clear and easy-to-understand form.

Consumers and representatives confirmed consumers' privacy was well respected, and their personal information kept confidential. Staff described their practices for protecting consumers’ privacy when providing care, and for keeping their personal information confidential on password protected computers. Computers were observed left on and viewable in the nurses' station during the Site Audit. Management issued a staff memo and ensured the timed screen inactivity shut down was activated. The service had a privacy policy to guide staff practice.

# 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 2(3)(a) was Not Met. While consumers and representatives expressed satisfaction with the assessment and planning of care, the Site Audit found gaps in the assessment of consumers potentially subject to environmental restraint, and at risk from pressure injuries and smoking. Evidence brought forward included:

* The Assessment Team found the service’s risk assessment processes were ineffective in assessing potential restrictive practices and other risks such as specialised nursing care and nutrition related risks.
* Consumers and representatives stated they were satisfied with the assessment and planning and the care delivered.
* Management and clinical staff described the comprehensive assessment and care planning processes, which included using validated assessment tools and considered risks to consumers’ health or well-being.
* Management explained how they assessed whether consumers were subject to environmental restrictive practices using the guidance in the National Aged Care Mandatory Quality Indicator Program. Management reviewed consumers using the Commission’s ‘Perimeter restraint self-assessment tool’ at the suggestion of the Assessment Team.
* The documented assessments for two consumers with pressure injuries did not photograph and record details of the wounds or the pressure injury prevention devices observed to be in use.
* Staff said they had not received training in relation to wound/pressure injury management.
* The documented risk assessment for a consumer that smoked did not show they had been assessed for all the risks. Staff explained they supported the consumer to mobilise to the smoking area and provided a smoking apron/fire blanket and call buzzer. The smoking apron, fire blanket cover and call bell were observed in place in the smoking area.

The provider’s response received 15 May 2024, acknowledged the issues identified in the Site Audit report and provided additional information and evidence of continuous improvement actions taken, or planned. The provider advised:

* All existing consumers have been assessed for risk of restraint utilising the Aged Care Quality and Safety Commission’s Perimeter Restraint Self-Assessment Tool. All incoming consumers will also be assessed for their risk of environmental restraint and either provided with swipe cards or consent will be sought and behaviour support plans put in place, as necessary.
* Management and maintenance staff have physically reviewed all entry/exit and egress points including assessing the accessibility of all swipe points for people with mobility or other limitations.
* The admission process and booklet will be amended to include information on swipe cards and promote free movement through all access and egress points.

I have further considered issues related to the delivery of safe and effective personal and clinical care under Requirement 3(3)(a). I acknowledge consumers and representatives were satisfied with the assessment and care planning process and none expressed concern about their ability to access their environment. I note the service acknowledged the issues identified by the Assessment Team in relation to assessment and planning, and immediately initiated continuous improvement actions to address the issues during the Site Audit. The improvement actions taken by the service should ensure the assessment and care planning process informs the delivery of safe and effective care and services. Therefore, on the balance of the evidence before me, I find Requirement 2(3)(a) Compliant.

I am satisfied the remaining 4 Requirements in Standard 2 are Compliant.

Consumers and representatives confirmed the service identifies consumers’ needs, goals and preferences including their advance care and end of life plans. Clinical staff explained how assessment and planning processes identified each consumer’s needs, goals and preferences and their end of life plans. Consumers’ care plans identified their current needs, goals, and preferences, including advance care plans and end of life wishes. The service had written policies and procedures to guide staff practice in assessment and planning and the identification of each consumer’s needs, goals, and preferences.

Consumers and representatives said they felt involved as partners in the assessment, planning and review of consumers’ care and services, along with other organisations and providers they wanted. Clinical staff described how care plans were developed in consultation with consumers, representatives, and other health professionals. Care documentation confirmed the assessment and care planning process was done in partnership with consumers, representatives, and others they wished to involve in their care.

Consumers and representatives said the service regularly updated them, through phone calls or in person, in relation to the outcomes of assessments and the health status of consumers. Clinical staff detailed the processes for informing consumers and representatives about the outcomes of assessments and any recommended changes to care plans. Care documents reflected regular contact with representatives to update them about consumer’s assessment outcomes and offer them a copy of the care plan.

Consumers and representatives confirmed that consumers’ care was reviewed regularly and reviewed when circumstances changed, or incidents occurred. Clinical staff explained how care plans were reviewed regularly to evaluate effectiveness and reviewed when consumers’ circumstances changed, or incidents occurred. Care planning documents confirmed they had been reviewed regularly and following an incident or change in circumstances.

# 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. | Not 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

This Quality Standard is assessed as Not Compliant as 1 of the 7 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 3(3)(a) was Not Met. While most areas of personal and clinical care were safe and effective, the Site Audit found wound and skin care, and potential environmental restraint were not always consistent with best practice. Evidence brought forward included:

* Consumers and representatives generally provided positive feedback in relation to the personal and clinical care provided by the service, and none expressed concern about their ability to freely access their environment.
* Staff generally demonstrated an understanding of best practice clinical care however, wound care and pressure injury prevention was not always consistent with best practice. Some consumers’ wounds were not cleaned and dressed according to the appropriate frequency. Records showed some wounds were not attended for periods over a week on multiple occasions.
* Documentation showed wounds were consistently not measured, photographed, charted and regularly examined by a registered nurse, in accordance with policies and best practice.
* Staff did not demonstrate a shared understanding of overall wound management processes and said they had not received wound care training in the service and were unsure if there was guidance policy.
* Management provided Continuous Improvement Plan actions to address wound management including development of procedures, staff training and accessing specialised consultancy services.
* The service’s pressure injury policy available to staff lacked guidance in relation to correct staging of pressure injuries and appropriate best practice principles for pressure injury care.
* One representative said they had requested a consumer’s nails be trimmed a week ago and it had not been done. The Assessment Teamed observed this consumer’s nails were trimmed on the second day of the Site Audit and all consumers had clean nails, fresh clothes and kempt hair. No other consumers or representatives raised any concerns in relation to the personal care provided.

The provider’s response received 15 May 2024, acknowledged the issues identified in the Site Audit report and provided additional information and evidence of continuous improvement actions taken, or planned. The provider advised:

* The current wound management procedure is being reviewed in consultation with the Clinical Quality & Safety Committee to reflect best practice. The final version will be approved out of session by 31 May 2024, to ensure staff have access to the updated procedures as soon as possible.
* Comprehensive education sessions for aged care clinical teams are scheduled during June 2024 to train staff on best practice wound management. Clinical educators will also provide staff with external and online education opportunities in relation to best practice skin care and wound management.
* Wound champions have been appointed to each aged care facility and they will be provided with additional training in more complex wound care during June and July 2024.
* The organisation has a clinical governance framework which applies to all clinical services provided by the organisation including residential aged care. However, the organisation had recognised the need for an aged care specific clinical governance framework and is currently finalising one with consultation in progress. The revised clinical governance framework will be finalised by 30 June 2024.

I note the service acknowledged the gaps identified in the Site Audit report in relation to the clinical care of wounds and skin integrity. In relation to environmental restraint, I am satisfied the service has appropriate processes in place and no consumers were subject to environmental restraint without the necessary steps being completed. In relation to wound care and pressure injury prevention, I accept the service moved quickly to initiate corrective actions however, these gaps in fundamental clinical care had not been self-identified. While the organisation has initiated improvement actions, which include providing additional staff training and clinical guidance, it is too early to determine whether these actions are sustainably embedded in the service’s culture and processes, and will be effective in delivering safe and effective clinical care to each consumer. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(a) Not Compliant.

I am satisfied the remaining 6 Requirements in Standard 3 are Compliant.

Consumers and representatives said high impact or high prevalence risks to consumers were effectively managed. Care planning documents identified risks to consumers using validated risk assessment tools and recorded effective risk mitigation strategies. Clinical staff detailed the processes for the identification, assessment and management of high impact or high prevalence risks associated with the care of each consumer. The service had documented policies and procedures to guide staff in relation to the management of high impact or high prevalence risks.

Consumers and representatives stated they had conversations with the service around end of life care and were confident the service would support consumers’ needs, goals and preferences. Staff explained how they maximised the comfort and dignity of consumers nearing the end of life in accordance with their documented needs and wishes. The service had a palliative care and end of life care policy to guide staff practice.

Consumers and representatives expressed confidence the service responded promptly and appropriately to a deterioration or change in consumers’ condition. Clinical staff provided examples and explained the process for identifying and responding to changes or deterioration in consumers’ health. Care planning documents showed deterioration or changes in condition were responded to appropriately. The service had resources to guide staff practice in identifying and responding to a deterioration in condition.

Consumers and representatives expressed satisfaction with the communication between staff at the service, and others involved in providing care and services. Clinical staff described how information about consumers’ current needs and condition was documented in the electronic care management system and shared effectively within the organisation, and with others involved in their care. Care planning documents were up to date and showed staff and others involved in providing care, had access to current information about consumers’ condition, needs and preferences.

Consumers and representatives said consumers had timely referrals to other individuals and organisations providing care and services. Clinical staff described effective processes for referring consumers to other health providers, when necessary. Care plans confirmed the timely input of other health professionals such as medical officers and allied health professionals. The service had written policies and procedures to guide staff in making referrals other health professionals.

Consumers and representatives confirmed staff took appropriate infection prevention and control measures. Clinical staff described the processes in place to prevent and control infections and promote antimicrobial stewardship such as increasing fluids, completing pathology testing prior to medication and providing personal hygiene. The service had documented policies and procedures to guide staff in preventing and controlling infections and promoting antimicrobial stewardship.

# 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

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements have been assessed as Compliant.

Consumers and representatives were satisfied the services and supports for daily living met consumers’ needs, goals, and preferences, and optimised their independence, well-being, and quality of life. Staff were aware of the lifestyle services and supports each consumer required to meet their needs and preferences. Care planning documents captured consumers’ life story, social affiliations, and their leisure and lifestyle needs, goals and preferences.

Consumers and representatives said the service supported consumers’ emotional, spiritual, and psychological well-being. Staff described the services and supports in place to promote consumers' emotional, spiritual, and psychological well-being, such as spending one-to-one time with consumers. Consumers’ care plans outlined the strategies in place to support their mental health and spiritual needs. The activities calendar showed one-to-one visits and church services.

Consumers and representatives said consumers were supported to participate in their community within and outside the service, maintain their relationships, and do things of interest. Staff described the supports in place for consumers to participate in the wider community and maintain important personal relationships. Initial assessments and care plans reflected each consumer’s interests prior to entering the service and identified ways they could continue to enjoy these interests. The monthly activity calendar was displayed in all communal areas.

Consumers and representatives said current information about consumers’ condition, needs, and preferences was effectively communicated between staff and others involved in providing services and supports for daily living. Staff and other health professionals described how they recorded and communicated current information about consumers’ condition and needs through the electronic care management system and shift handovers.

Consumers and representatives said the service provided timely and appropriate referrals to other individuals and organisations providing care services when the service could not provide the support needed. Consumers’ care plans confirmed the service collaborated with other service providers to support the diverse needs of consumers. Staff could describe how consumers and representatives were actively involved in discussing and consenting to referrals. Documents confirmed the service had established links with other individuals and organisations to ensure consumers had access to a range of external services and supports.

Consumers and representatives said the meals provided were of good quality, quantity and variety and there was food available in between meals. Staff knew consumers’ dietary needs and preferences, and any dining support needed. Staff confirmed they could provide consumers with food and drink anytime outside mealtimes. Care planning documents detailed consumers’ dietary requirements and preferences, along with any recommendations made by the dietitian. Meal service appeared calm and unhurried with consumers receiving appropriate assistance from staff in a dignified and timely manner.

Consumers and representatives said the equipment provided was safe, suitable, clean, well maintained, and they knew how to report any maintenance concerns. Staff confirmed there was sufficient suitable equipment and maintenance issues were attended to efficiently. Equipment appeared to be safe, clean, well maintained, and suitable for consumers.

# 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

This Quality Standard is assessed as Compliant as 3 of the 3 Requirements have been assessed as Compliant.

Consumers and representatives said they could personalise their rooms and the service was welcoming, homely and optimised consumers’ sense of independence, interaction, and function. Staff said they respect the service is consumers’ home and enjoy assisting them to maintain their surroundings as they wish. Consumers’ rooms were decorated with personal possessions, and consumers and visitors were observed utilising various areas within the service.

Consumers and representatives said the service was clean, comfortable, well-maintained, and they could move freely throughout the service both indoors and outdoors. Management and staff explained the processes for reporting maintenance issues. Maintenance and cleaning staff detailed the service’s cleaning and maintenance schedules which were all up to date.

Consumers and representatives said the furniture, fittings, and equipment were safe, suitable, clean, and well-maintained. Staff knew how to make maintenance requests and records showed they were actioned promptly. Furniture, fittings, and equipment were observed to be safe, clean, and suitable for use.

# 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

This Quality Standard is assessed as Compliant as 4 of the 4 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 6(3)(d) was Not Met. Consumers and representatives described how the service used feedback to improve the quality of care and services. However, there were different systems for recording feedback which meant not all feedback was captured on the feedback register and staff were not always sure where to record feedback. Evidence brought forward included:

* Management provided examples of improvements that had resulted from consumer feedback and complaints however, these were not always recorded on the feedback register or the Continuous Improvement Plan.
* Management acknowledged not all feedback and complaints were being recorded on the Victorian Health Incident Management System (VHIMS) in accordance with the organisation’s policy.
* Clinical staff advised feedback was recorded in the progress notes on the electronic care management system and they had not received any training on the feedback and complaint processes such as using the Victorian Health Incident Management System.
* Management acknowledged the service’s feedback management systems were disjointed and a Continuous Improvement Plan action was commenced during the Site Audit to improve the feedback management process by 30 June 2024. The improvement actions included staff education in use of the Victorian Health Incident Management System and ensuring all consumer feedback was consistently recorded.

The provider’s response received 15 May 2024, acknowledged the inconsistencies identified in the Site Audit report and provided additional information and evidence of continuous improvement actions taken, or planned. The provider advised:

* The service acknowledges that some consumer feedback such as from menus and aged care residents’ relative meetings was not being recorded on Victorian Health Incident Management System.
* Staff were unaware of where to document informal feedback. Currently informal feedback is being captured in the electronic care management system.
* Staff training on use of the Victorian Incident Management System is scheduled for completion by 30 June 2024.
* All informal and formal feedback (including feedback from meetings, menus and activity programs) will be logged on the Victorian Incident Management System in accordance with the organisation’s policy. All feedback will be reported and monitored by the Residential Quality Care Committee, Clinical Quality and Safety Committee and Executive.

I have further considered issues related to staff training in documenting feedback and complaints under Requirement 7(3)(d). I do not consider routine care requests to be feedback or complaints. I note the service acknowledged inconsistencies in how staff documented feedback and complaints and had initiated various continuous improvement actions to rectify these issues. While feedback was not always documented consistently, there is evidence the service took improvement actions in response to feedback, and consumers and representatives reported their feedback did result in improvements being made by the service. Therefore, on the balance of the evidence before me, I find Requirement 6(3)(d) Compliant.

I am satisfied the remaining 3 Requirements in Standard 6 are Compliant.

Consumers and representatives confirmed they were supported to provide feedback and make complaints through feedback forms, resident/relative meetings, surveys, and by phone or email. Staff described the avenues available for consumers and representatives to make a complaint and how they supported them to raise any concerns. The service had a feedback and complaint policy, and feedback forms and collection boxes were located throughout the service.

Consumers and representatives were aware of other avenues for raising a complaint such as through the Commission, advocacy services, or with the help of family or friends. Management and staff were aware of external complaint avenues, advocacy and language services, and assisted consumers to access these services. The resident handbook included information about advocacy and interpreting services, and how to complain internally and externally.

Most consumers and representatives confirmed the service responded appropriately and promptly to feedback and complaints. One representative advised they had asked for staff to cut their consumer’s nails a week ago however, this request was completed during the Site Audit. Consumers and representatives confirmed when things went wrong, the service apologised, communicated effectively, and practiced open disclosure. The service had an open disclosure policy and staff could explain open disclosure and provide examples of using it. Management stated feedback/complaints and incidents were recorded on the Victorian Health Incident Management System however, not all staff were aware of this process.

# 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

This Quality Standard is assessed as Not Compliant as 1 of the 5 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 7(3)(d) was Not Met. While consumers and representatives said staff had the appropriate skills and knowledge to deliver safe and effective care, the Site Audit found the completion of mandatory staff training was generally behind schedule and did not sufficiently address wound care and documenting complaints consistently. Evidence brought forward included:

* Training records showed most staff had not yet completed all modules of their mandatory training for 2023–2024, which was due for completion by 30 April 2024.
* The service had systems to send staff reminders to complete their mandatory training however, at the time of the Site Audit completion rates for modules varied from below 40% to over 90%.
* Staff confirmed receiving orientation education and ongoing training and support from the service. Most staff confirmed they had not completed all their 2023-2024 mandatory training but had received notification it was due by 30 April 2024.
* While some clinical staff had attended external training in wound care, management acknowledged there was a gap in providing wound care training to staff.
* Management acknowledged the issues identified and provided Continuous Improvement Plan actions to address the completion of staff training, including training in wound care and recording feedback and complaints.

The provider’s response received 15 May 2024, acknowledged the inconsistencies identified in the Site Audit report and provided additional information and evidence of continuous improvement actions taken, or planned. The provider advised:

* The service acknowledged there was variation in the completion of mandatory annual staff training. However, annual mandatory staff training was scheduled for completion by 30 April 2024, which had not been reached at the time of the Site Audit.
* Mandatory training completion is strongly supported by management through various strategies such as sending regular reminders, providing regular advice on training completion, and encouraging staff to use double staffing time to complete their mandatory training.
* Comprehensive education sessions in wound care have been scheduled for all aged care clinical teams throughout June 2024. Clinical educators have also provided staff with external and online education opportunities to further enhance their knowledge on best practice skin care and wound management.
* Wound champions have been identified for each aged care facility and they will receive additional education sessions in more complex wound management in June and July 2024.

I have further considered the clinical care of wounds under Requirement 3(3)(a). I note the service acknowledged inconsistencies in the completion of mandatory staff training but the deadline for completion had not been reached at the time of the Site Audit. I accept the service moved quickly, during and since the site audit, to initiate various improvement actions which included scheduling additional staff education, particularly in wound care and documenting complaints. While the organisation has initiated improvement actions, it is too early to determine whether these actions are sustainably embedded in the service’s processes and culture, and prove effective in ensuring the workforce is trained and supported to deliver the outcomes required by these Standards. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(d) Not Compliant.

I am satisfied the remaining 4 Requirements in Standard 7 is Compliant.

Consumers and representatives felt there was enough staff and said, although staff were busy, consumers received the care they needed in an unrushed and timely manner. Staff said there was enough staff, and they could deliver appropriate care in a timely manner. Management said the mix and number of staff was adequate to provide safe and quality care. Management explained the rostering process and how they tried to ensure the continuity of agency staff. Call bell records showed most calls were answered within 5 minutes and management advised any call bell responses over 10 minutes were investigated according to policy.

Consumers and representatives said staff were kind, respectful and caring when providing care. Staff knew consumers personally and understood their background, identity, needs and preferences. Staff were observed being attentive and respectful to consumers, and using their preferred names. The service had written policies, procedures and training to guide staff in supporting consumers’ identity, culture and diversity.

Consumers and representatives said staff were capable and had the knowledge to provide the care and support they required. Management described the recruitment and induction process and how they ensured all staff had the required competencies, qualifications, registrations and security checks for their roles. New staff said they were well supported by management with orientation training and buddy shifts. Position descriptions specified the core competencies and capabilities for each role and duty lists provided guidance about specific duties.

Consumers and representatives expressed satisfaction with the quality and performance of staff. Management detailed how they regularly assess, monitor, and review the performance of the workforce. Management described the annual performance appraisal process and how they undertook continuous assessment during team meetings, through observations and feedback processes. Staff confirmed participating in probationary and annual performance reviews. While annual performance appraisals were complete for all staff for 2023, the annual performance appraisals for 2024 were behind schedule. Management provided a Continuous Improvement Plan action dated March 2024 to address the incomplete performance appraisals.

# 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. | 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. | 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

This Quality Standard is assessed as Not Compliant as 1 of the 5 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 8(3)(c) was Not Met. While the organisation had governance systems related to information management, continuous improvement, financial and workforce governance, regulatory compliance, and feedback and complaints the Site Audit found they were not always effectively applied and controlled. Evidence brought forward included:

* The Assessment Team identified gaps in the governance of information management, the training and performance of the workforce, and the consistent recording of feedback and complaints.
* The service’s wound care policy was still in draft form and was not available to guide staff practice.
* Workforce mandatory training and performance appraisals for 2024 were behind schedule. There was no staff training provided in relation to wound care, and documenting feedback and complaints in the relevant system.
* Management acknowledged the issues identified and provided Continuous Improvement Plan actions to address the issues.

The provider’s response received 15 May 2024, acknowledged the inconsistencies identified in the Site Audit report and provided additional information and evidence of continuous improvement actions taken, or planned. The provider advised:

* Comprehensive education and training will be provided to staff in areas including best practice wound care, recording feedback and complaints on the Victorian Incident Management System, and completion of mandatory staff training.
* Other actions identified on the organisation’s Continuous Improvement Plan included reviewing and updating; the wound management procedures, the system for managing staff performance appraisals, the monitoring of feedback and complaints, the clinical governance framework.

I have further considered issues related to the provision of wound care under Requirement 3(3)(a), managing feedback and complaints under Requirement 6(3)(d), and staff training and support under Requirement 7(3)(d). I note the service acknowledged gaps in some areas of organisational governance and moved quickly to initiate various improvement actions which appear likely to address the issues identified. However, the service’s existing governance arrangements had not self-identified several deficits identified in the Site Audit and were not effective in identifying and promptly correcting departures from compliance. While the organisation has initiated improvement actions, it is too early to determine whether these actions prove effective in ensuring the governance systems are effective on an ongoing basis. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(c) Not Compliant.

The Assessment Team recommended Requirement 8(3)(e) was Not Met. The organisation had a clinical governance framework which addressed antimicrobial stewardship, the minimisation of restraint, and the use of open disclosure. However, the Site Audit found the organisation did not have suitable documented policies or procedures to guide staff in the clinical care of wounds and the minimisation of environmental restrictive practice. Evidence brought forward included:

* Staff and management described how clinical governance framework included policies and procedures pertaining to antimicrobial stewardship, the minimisation of restrictive practices, and the use of open disclosure.
* Consumers and representative described receiving an apology when something went wrong and discussing strategies to prevent a reoccurrence of the incident.
* The service had policies in relation to assessment, restrictive practices and a documented clinical governance framework, however, the Assessment Team did not consider these adequately assessed the potential risk of environmental restrictive practices and did not reference the Commission’s perimeter restraint tool.
* Care planning documents demonstrated compliance with the organisation’s policies for antimicrobial stewardship and open disclosure.
* The organisation’s clinical governance framework did not include a finalised documented policy or procedure for the clinical care of wounds.
* Staff confirmed they did not have access to a wound care policy or procedure on the service’s intranet.
* Management provided Continuous Improvement Plan actions which included assessing all existing and new consumers for the risk of environmental restraint utilising the Aged Care Quality and Safety Commission’s Perimeter Restraint Self-Assessment Tool. Reviewing the accessibility of all access points and updating the restrictive practice policy and other documents to include perimeter restraint.

The provider’s response received 15 May 2024, provided additional information and evidence in relation to the organisation’s clinical governance framework. The provider advised:

* The organisation has a clinical governance framework which applies to all clinical services provided by the organisation including residential aged care. However, the organisation has recognised the need for an aged care specific clinical governance framework and is currently finalising one with consultation in progress. The revised clinical governance framework will be finalised by 30 June 2024.
* The organisation is also currently reviewing the clinical care audit process to make it less cumbersome and ensure it is in line with best practice and the Quality Standards.
* The current wound management procedure is being reviewed in consultation with the Clinical Quality & Safety Committee to reflect best practice. The final version will be approved out of session by 31 May 2024, to ensure staff have access to the updated procedures as soon as possible.
* The organisation has taken various improvement actions which include assessing all existing and new consumers for the risk of environmental restraint utilising the Aged Care Quality and Safety Commission’s Perimeter Restraint Self-Assessment Tool, reviewing the accessibility of all entry/exit points, and updating the restrictive practice policy and other documents to include perimeter restraint.

I have further considered the issues identified in relation to the delivery of clinical wound care under Requirement 3(3)(a) and the assessment and planning of care under Requirement 2(3)(a). I note the Site Audit found the organisation had a general clinical governance framework which addressed antimicrobial stewardship, minimising the use of restraint and open disclosure, but identified the need to better consider potential environmental restraint. While there may be scope to improve the existing documentation, I am satisfied no consumers were subject to environmental restraint without the necessary steps being completed. I further acknowledge the service had identified corrective actions on their Continuous Improvement Plan which included revising their clinical governance framework and related policies. Given the provider’s improvement actions taken during and since the site audit, I am satisfied the service’s revisions to their existing clinical governance framework will address the issues identified in the Site Audit report. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(e) Compliant.

I am satisfied the remaining 3 Requirements in Standard 8 are Compliant.

Consumers and representatives said the service was well run and they had opportunities to inform the design, delivery, and evaluation of services through care conferences, meetings, the community advisory committee and feedback processes. Management explained various ways consumers and representatives were encouraged to be involved in decisions about the service and their feedback resulted in changes being made.

Consumers and representatives expressed feeling safe in the service and described the environment as inclusive and providing quality care and services. The organisation's governing body (the Board) set clear expectations and policies to support the delivery of safe, inclusive, and high-quality care and services. The Board implements quality assurance measures and was accountable for the performance of the service, continuous improvement, and ensuring the Quality Standards were met.

The service had effective risk management systems and practices to manage high impact or high prevalence risks associated with care of consumers, identifying, and responding to abuse and neglect, supporting consumers to live the best life they can, and managing and preventing incidents. Risks and incidents were identified, managed, and reported on regularly. Consumers and representatives confirmed consumers were supported to live the best life they could.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)