Performance

Report

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| Name of service: | Latrobe Valley Village Hostel |
| Service address: | 5 Ollerton Avenue MOE VIC 3825 |
| Commission ID: | 3113 |
| Approved provider: | Latrobe Valley Village Inc |
| Activity type: | Site Audit |
| Activity date: | 19 September 2022 to 21 September 2022 |
| Performance report date: | 11 November 2022 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Latrobe Valley Village Hostel (**the service**) has been prepared by M. Nassif, 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; 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 2 November 2022.

# 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 | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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)(b) – Ensure effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 6(3)(c) – Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 7(3)(a) – Ensure 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.
* Requirement 8(3)(d) – Ensure effective risk management systems and practices in relation to high impact or high prevalence risks associated with the care of consumers.
* Requirement 8(3)(e) – Ensure there is a clinical governance framework which includes antimicrobial stewardship, minimising the use of restraint and open disclosure.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers said they are treated with dignity, respect and their identities valued. Staff knew about individual consumers needs and things of importance to them and were observed being respectful during interactions. Care planning provided information on consumers’ background, identity, and culture and staff were familiar with these details. The service had policies supporting consumer diversity, dignity and respect.

Consumers from culturally diverse backgrounds said their culture is respected and staff supported them to express their cultural identity and interests. Staff knew consumers’ cultural background and how this influenced their care delivery.

Consumers and representatives said they are supported to exercise choice and independence regarding how their care and services are delivered and to maintain connections and relationships. Staff could describe how each consumer is supported to make their own decisions and maintain relationships of choice. Care planning documents identified individualised choices for care and services, supports for maintaining independence and important connections.

Staff described assessment of risk-taking activities occurring in consultation with consumers, representatives, and health professionals. Care documentation described areas in which consumers are supported to take risks to live the life they wish. The organisation has documented policies on supporting consumers to take risks and a process with accompanying dignity of risk consent forms.

Consumers said adequate information was provided to assist them make choices about their lifestyle and care. Information was provided in various suitable forms about activities occurring inside the service and outside in the community, meal options and activities of daily living. Staff described several ways they provided current information to consumers to allow them to make their own choices.

Consumers confirmed their privacy is respected. Staff were observed respecting consumer privacy including by knocking on their doors, waiting for a response before entering and closing doors to deliver personal care. Staff described steps they take to keep personal information confidential and maintain the privacy of consumers. The service had policies and procedures to guide staff practice for maintaining consumer privacy, and the collection, disclosure, security, storage, and use of information relating to consumers.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The Assessment Team recommended Requirement 2(3)(e), was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 2(3)(e), the Site Audit report identified the following deficiencies:

* One example of a named consumer who had an unwitnessed fall and neurological observations and pain assessment were not appropriately completed and documented following the incident, and care planning documentation not updated or reviewed for effectiveness.
* Staff acknowledged 15 care planning documents were behind schedule for review. Staff said this was due to staff shortage.

The provider’s response provided clarifying information in relation to the deficits in support of this Requirement being compliant:

* The provider clarified that a subsequent review of CCTV video confirmed a consumer had not fallen onto the floor and the overall response by the service was appropriate given it was not an unwitnessed fall.
* The provider outlined several strategies now in place to bring care plan reviews up to date, including deploying additional registered staff to assist with the backlog of annual and monthly care reviews.

The Site Audit report found the service had policies and procedures for recording and reporting incidents and reviewing care plans regularly and when there is a change in circumstances. Progress notes demonstrated clinical staff reviewed individual consumer’s needs monthly as part of the resident of the day process.

As no further named consumer example was brought forward in the Site Audit report, the evidence presented under this Requirement is insufficient alone, to support care and services are not reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Therefore, based on the evidence before me, I find Requirement 2(3)(e) compliant.

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

Consumers and representatives are generally satisfied their current needs and preferences are identified in the care planning process and any risks to their health and well-being are assessed. Staff explained how the service undertakes assessment and care planning, factoring in risks, to inform the delivery of safe and effective care and services. This was evident in care planning documents.

Staff described how they use the admission checklist and create individualised electronic care planning records which include advance care and end of life plans, where the consumer wishes. Consumers and representatives said the assessment and care planning processes captured their needs and preferences and the service provided opportunities to discuss end of life care. Care planning documentation addressed consumers’ current needs, goals and preferences and includes advanced care planning and end of life planning.

Consumers and representatives felt they can contribute as partners in the assessment and planning process and involve other providers of care they wanted to. Staff explained how consumers and representatives, as well as other individuals and organisations, were included in assessment and planning of care and services. Care planning documents showed the involvement of consumers, representatives, and other health professionals in the assessment, planning and review processes.

Consumers and representatives said the service maintained good communication with them and staff keep them updated in relation to clinical issues whenever needed. Consumers and representatives were not aware of care plans being readily available to them. Management acknowledged they have not actively advised consumers/representatives they can access their care plans, however stated that care planning documents would always be provided on request. Staff described the different methods they use to communicate the outcomes of assessment and planning to consumers and representatives. Policies and procedures direct staff in communicating the outcomes of assessments and planning to consumers and representatives and making care plans available.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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

The Assessment Team recommended Requirement 3(3)(b), was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 3(3)(b), the Site Audit report identified several deficiencies. I consider the following relevant to Requirement 3(3)(b):

* In relation to falls management, one consumer had 9 falls since June 2022 and the consumer was not appropriately reviewed or monitored for pain or neurological condition post fall. There was no evidence that the service is developing strategies to minimise falls. The consumer’s current falls management strategies, such as call bell within reach and floor sensor, were not observed to be in place.
* In relation to wound management, three consumers had wounds that were not adequately assessed and monitored. The measurements and other clinical characteristics of the wounds were not regularly recorded as part of clinical monitoring of wound healing. Clinical staff stated they are aware of inconsistencies in the management of wounds and said they are short staffed and do not have time to meet the wound care requirements. Clinical staff said there is no guidance on frequency of wound photos or how often wounds should be reviewed by a registered nurse. Management advised staff will receive further education in wound management policy and procedures.
* In relation to management of pressure injuries, the service had ten active pressure injuries. Gaps were identified in the care planning documents of one consumer with 2 pressure injuries resulting in wounds. There was no evidence that wounds were appropriately monitored, as discussed above. Additionally, care planning documents did not reflect pressure area care management. The consumer’s wound charts demonstrated review of one of the wounds began on 26 October 2020. The first photo for the wound was not documented until 27 January 2021 and, at the time of the Site Audit, the wound had deteriorated since it was first recorded.

The provider’s response detailed comprehensive corrective actions undertaken, commenced or planned in relation to the deficiencies identified including:

* Several strategies in place to improve the management of high impact/high prevalence risks, such as falls and wounds, including developing an updated Falls Risk Assessment Tool to be completed after each fall incident and updating the wound and pressure injury assessment process.
* Additional training opportunities which will be provided to staff.

While I acknowledge the service has taken appropriate actions to address the deficiencies identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Therefore, based on the evidence before me, I find Requirement 3(3)(b) non-compliant.

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

Consumers and representatives were satisfied the care is tailored to their needs, is safe, effective and it optimises their health and wellbeing. The service had policies and procedures to guide staff in the delivery of best practice clinical care such as wound management, restraint practices, skin integrity and medication. Documentation evidenced restrictive practices managed at the service in line with best practices and staff described alternate interventions to manage behaviours.

Consumers and representatives confirmed staff have spoken to them about advance care plans. Staff described how they maintain comfort and dignity for consumers nearing the end of life, according to their end-of-life pathway and care plan. The service had procedures on palliative approach, advanced care planning and voluntary assisted dying that provided guidance to staff on palliative approach trajectory.

Care planning documents showed deterioration or change in consumer’s mental health, cognitive or physical function or capacity was identified and responded to promptly. Representatives stated they are happy that any changes in condition were recognised and acted upon appropriately. Management described how changes in consumer’s condition and care needs are discussed within the care team, and monitored via clinical management meetings, using relevant clinical indicators.

Consumers and representatives were happy with the delivery of care and how any changes in a consumer’s condition, needs or preferences were documented and communicated. Staff described how changes in consumers’ needs and preferences are communicated through a verbal handover process, handover sheets, accessing care plans, meetings, electronic messages, and paper-based documentation.

Care planning documents showed consumers are referred to other health care professionals and services. Consumers and representatives said they are satisfied they received timely and appropriate referrals to other medical services when required. Staff described the referral process and advised the service is supported by a physiotherapist 5 days a week, a podiatrist that visits monthly and various other health professionals as needed.

Consumers and representatives said they are satisfied with the management of infectious outbreaks by the service, including for COVID-19. The service had documented policies and procedures to support the minimisation of infection risks and the promotion of antimicrobial stewardship. Staff demonstrated an understanding on how to minimise antibiotics use and were observed using infection preventative strategies.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers and representatives said the services and supports for daily living meet their needs, goals and preferences and help maintain their independence, well-being, and quality of life. Staff demonstrated knowledge of consumers’ needs and preferred activities. Care planning documents identifies consumers’ life story and choices, lifestyle likes and dislikes, social affiliations, and spiritual and religious needs, and provides information about supports consumers require to do the things they want to do.

Consumers said the services and supports for daily living promote their emotional and spiritual well-being. Staff described the emotional, spiritual, and psychological supports in place for specific consumers and how they facilitate regular visits and support contact between consumers and family members. Care planning documents outlined consumers’ emotional and spiritual needs.

Consumers said they are supported by the service to maintain social and personal relationships, participate in their community, and do things they want to. Staff explained how they supported individual consumers to maintain social and personal relationships and do the things of interest to them. Care planning documents identified the activities and social connections important to consumers and how they are to be supported.

Staff said current information about consumers’ needs and condition is shared at handover and preferences are obtained by speaking with consumers daily. Staff detailed the process for communicating internally at the service and externally to others where responsibility for care is shared. Tools such as the service’s handover sheet and electronic reminders on the care planning system demonstrated effective communication.

Staff provided examples of timely and appropriate referrals made to other providers of care and services including external organisations and volunteers. Consumers said the service has referred them to external providers to support their care and service needs. Care planning documents confirmed the service collaborates with external providers of care are services.

Consumers said the meals provided are varied and of suitable quality and quantity. The service demonstrated it has a process in place for consumers to choose their meal preferences each day and there are alternatives available. Staff described how they meet individual consumer dietary needs and preferences and how any changes are communicated between staff. Consumers’ dietary needs, allergies, likes, and dislikes were accurately recorded in the care planning documents.

Consumers said they feel safe using the equipment provide and it is suitable for their needs, clean and well maintained. Staff knew how to report any maintenance issues, and said issues were attended to promptly by maintenance staff. Maintenance documentation showed preventative and corrective maintenance was scheduled/logged and addressed in a timely manner.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers said they feel at home at the service, and it is a nice place to live. Consumers’ rooms were personalised with furniture, photographs, and artwork. Staff said they supported consumers to personalise their rooms to promote a sense of belonging and independence. The service environment appeared welcoming with dementia enabling features of design and safety. The service is easy to navigate with a directory board and clear signage directing consumers and visitors.

Cleaning staff and an on-site maintenance team said they ensure the environment is safe, clean, and well maintained. Records show the service has processes and systems in place for cleaning and identifying and recording hazards and maintenance issues. Consumers were observed utilising indoor and outdoor areas and moving freely around the service. Staff were seen assisting consumers to move around the service.

Consumers and representatives said the furniture, fittings, and equipment are safe, clean, well maintained, and suitable. Consumers said they feel safe when staff are providing care using the equipment with them. Staff were aware of the maintenance and cleaning schedules and knew how to report any maintenance issues. Maintenance documentation confirmed regular maintenance of the service environment, although there were some minor gaps in recording the completion of the task.

# 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Assessment Team recommended Requirement 6(3)(c) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 6(3)(c), consumers and representatives said management promptly addressed and resolved their concerns following the making of a complaint. Management provided examples of recent actions taken in response to complaints made and feedback provided by consumers/representatives which evidenced a timely resolution. However, the service did not demonstrate an open disclosure process was used when things went wrong. The Site Audit report identified the following deficiencies:

* Multiple recent incidents were identified where the service did not appear to apply the open disclosure process and consumer representatives were unaware of the incidents occurring.
* Staff could not articulate that if something went wrong, they would apologise to the consumer and/or their representative, explain what happened and the actions taken to resolve the issue and prevent it from happening again (the key elements of open disclosure).
* Management acknowledged that representatives should have been contacted in relation to recent incidents, as part of the open disclosure process. Management conceded open disclosure was not an embedded procedure and there was no stand-alone policy.
* The service was not able to demonstrate staff training in relation to the open disclosure process.

The provider’s response detailed comprehensive corrective actions undertaken, commenced, or planned in relation to the deficiencies identified including:

* Developing an Open Disclosure policy, procedures and updating 5 other policies to better reference open disclosure. All staff members will be notified of the finalised documents and receive training.
* Development of a new form titled ‘Incident Investigation – Open disclosure’ to be completed in addition to the Hazard/Incident form which will ensure staff follow the open disclosure process.

While I acknowledge the service has taken appropriate actions to address the deficiencies identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did not demonstrate an open disclosure process is used when things go wrong. Therefore, based on the evidence before me, I find Requirement 6(3)(c) non-compliant.

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

Consumers and representatives said they are encouraged and supported to provide feedback and would feel comfortable making a complaint, should the need arise. Management described different avenues available to consumers and representatives if they wanted to provide feedback or make a complaint. Hardcopy feedback forms, flyers and brochures detailing internal and external complaint avenues were seen displayed at the service.

Consumers and representatives said they are aware of other avenues for raising a complaint. Staff described how they act as advocates for consumers by communicating concerns to management on their behalf, encouraging them to provide feedback and assisting consumers to complete feedback forms as required. Staff and management were aware of how to access interpreter and advocacy services for consumers. Information on advocacy services was and brochures, in multiple languages, on making a complaint were displayed at the service.

Consumers and representatives said the service made improvements based on their feedback. Management described how feedback and complaints are trended, analysed, and used to improve the quality of care and services. Consumer and staff meeting minutes confirmed that feedback and complaints from consumers/representatives are discussed at each meeting, and actions taken by the service are evaluated.

# 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. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Assessment Team recommended Requirement 7(3)(a) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 7(3)(a), the Site Audit report identified the following deficiencies:

* Most consumers and representatives considered there were too few staff at times and described negative impacts on consumers.
  + One consumer said their indwelling catheter bag is not changed unless they call for staff. The consumer said on one occasion the bag was giving them pain due to the weight of the bag.
  + One consumer said they have to wait a long time for staff to come assist them to go to the toilet and they have had accidents waiting for staff.
  + One consumer’s representative said staff forgot the consumer when they were outside in the cold for several hours and waiting for staff to assist to come back inside. Call bell data for the consumer demonstrated, in a one-month period, the consumer had to wait over approximately 20 minutes on 5 occasions, with the longest wait time being 81 minutes. Management said the excessive call bell response times were due to a misplaced call bell pendant which staff could not find to cancel.
  + One consumer’s representative said they often find the consumer dehydrated and staff don’t have time to observe that the consumer requires assistance to drink.
* Staff expressed concerns around staffing levels and their ability to deliver quality care, for example, staff expressed concerns about monitoring the safety of consumers with high falls risks, mainly in the memory support unit where there are 7 consumers who require two-person assistance and there are only 2 staff on duty. Staff attributed gaps in clinical documentation to not having time to complete the records due to lack of staff.
* The service did not demonstrate any analysis of the falls data to find out when the majority of falls occur or if there is a need to adjust number and skill of staff rostered to address falls. Management acknowledged this however responded that increased falls was due to the service being in an outbreak.
* A Board initiated call bell audit on 27th July 2022 based on the Resident/Relative Experience Survey showed slow response to call bell was an issue.

The provider’s response detailed comprehensive corrective actions undertaken, commenced, or planned in relation to the deficiencies identified including:

* Detailing a number of strategies to address staff shortages through ongoing recruitment and improved workforce planning, rostering and allocation of staff.
* Upgrade to electronic shift rostering solution with additional features to better target shifts.
* Actions underway to improve the catchment and placement of trainee staff and the recruitment and retention of staff generally.

While I acknowledge the service has taken appropriate actions to address the deficiencies identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. I have also given weight to feedback from consumers on the negative impacts staffing levels have had on them. The service did not demonstrate the number and mix of members of the workforce enabled the delivery and management of safe and quality care and services. Therefore, based on the evidence before me, I find Requirement 7(3)(a) non-compliant.

I am satisfied the remaining 4 Requirements in Quality Standard 7 are compliant.

Consumers and representatives said staff are kind, caring and gentle when providing care. Staff were observed to always greet consumers by their preferred name and speak about consumers respectfully using their preferred name. Management said the service has a suite of documented policies and procedures to ensure care and services are delivered in a respectful, kind, and person-centred manner.

Consumers and representatives said staff perform their duties effectively, and they are confident staff have the qualifications and knowledge to meet their care needs. Management said staff are required to complete mandatory orientation and training on commencement. Position descriptions included key competencies and qualifications.

Consumers and representatives said staff knew what they were doing to deliver the care and services needed. Management explained annual mandatory training is completed as scheduled, as well as having an online training portal for staff to access. Staff said the service provides mandatory and supplementary training to support them to provide quality care. Records showed training completion is monitored centrally and followed up with staff by management at the service.

Staff reported having annual appraisals and described the process. The service had policies and procedures in place to guide the process for managing staff performance. Management described the process for assessing, monitoring, and reviewing staff performance. Documentation demonstrated most staff had completed their annual performance appraisal.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-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. | Non-compliant |

Findings

The Assessment Team recommended Requirements 8(3)(d) and 8(3)(e) were not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 8(3)(d), the organisation provided a risk management framework and policies relating to; managing high impact and high prevalence risks, identifying, and responding to abuse and neglect, supporting consumers to live the best life they can and managing and preventing incidents. However, the Site Audit report identified the following deficiencies:

* As outlined under Requirement 3(3)(b), examples of named consumers experiencing falls show that the service has not been appropriately managed these types of incidents for each consumer to prevent reoccurrence.
* The service was unable to provide information in relation to clinical indicators analysis at the service that are utilised to inform the review of policies, procedures, and practice to support the effective management of high impact or high prevalence risks.
* Incident data is recorded and reported to the Board, however, the effectiveness of fall prevention strategies was not analyzed and discussed when there were high numbers of falls in a month. Incident data is not analysed or used to review for the training needs of staff in managing and preventing incidents. Management stated they will review the process of post incident management and evaluation of care, along with the implementation of updated policies.
* Staff were unable to identify the current high impact or high prevalence risks at the service.

The provider’s response and detailed comprehensive corrective actions undertaken, commenced, or planned in relation to the deficiencies identified including:

* Developing additional tools to support its risk management systems and practices including an end of shift check list to be embedded into the shift handover process and a new ‘Incident Investigation – Open Disclosure’ form to be completed in addition to the Hazard/Incident form.
* Developing a root cause analysis trigger framework guided by the Serious Incident Response Scheme functions that will result in the most serious incidents being subjected to a root cause analysis.

While I acknowledge the service has taken appropriate actions to address the deficiencies identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did not demonstrate effective risk management systems and practices in relation to high impact or high prevalence risks. Therefore, based on the evidence before me, I find Requirement 8(3)(d) non-compliant.

Regarding Requirement 8(3)(e), the organisation has a clinical governance framework which includes policies and procedures covering antimicrobial stewardship and minimising the use of restraint and staff explained their roles and responsibilities in these areas. However, the Site Audit report identified the following deficiencies:

* The service did not have a policy covering the process of open disclosure. Management stated this will be included in their new complaints policy/process and staff training will be provided when the policy is implemented.
* Staff were not aware of open disclosure and could not explain the main aspects of the process.
* Incident forms did not demonstrate an open disclosure process is used and this was confirmed by consumer’s representatives who were not made aware of some incidents and said open disclosure did not occur post incidents.

The provider’s response detailed comprehensive corrective actions undertaken, commenced, or planned in relation to the deficiencies identified including:

* Development and implementation of a quality assurance framework in line with the Aged Care Quality and Safety Commission’s clinical governance framework guidance.
* Development of an open disclosure procedure and associated forms, along with additional staff training and support in relation to open disclosure.

While I acknowledge the service has taken appropriate actions to address the deficiencies identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service had a clinical governance framework which included policies addressing antimicrobial stewardship and restrictive practices, however, did not demonstrate a clinical governance framework that adequately covered open disclosure. Therefore, based on the evidence before me, I find Requirement 8(3)(e) non-compliant.

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

Management described how consumers and representatives are supported to be engaged in the development, delivery and evaluation of care and services including: monthly consumer meetings, satisfaction surveys, care planning conversations and conferences, and a feedback and complaints management system. Consumers and representatives said they felt involved as a partner in determining the care and services provided.

Management described the organisational structure and how the Board oversees operations and is accountable for the culture and the delivery of quality of care and services. The Board meets regularly and receives various detailed reports from management and the subcommittees to ensure the service is meeting the Quality Standards and the quality of care delivered is best practice.

Management described how the organisation had effective organisation wide governance systems in relation to information management, continuous improvement, financial governance, the workforce, regulatory and legislative compliance, and feedback and complaints management. For example, management said compliance with the governance systems was monitored through the risk management system and the organisational governance system.

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)