Performance

Report

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| Name of service: | Performance report date: |
| Mark Donaldson VC House | 12 October 2022 |
| Commission ID: | Activity type: |
| 0955 | Site Audit |
| Approved provider: | Activity date: |
| RSL LifeCare Limited | 15 August 2022 to 17 August 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 Mark Donaldson VC House (the service) has been considered by Melissa Frost, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 20 September 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-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 2(3)(c) – the Approved Provider ensures assessment and planning is based on ongoing partnership with the consumer and others that the consumer wishes to involve, and includes other organisations.
* Requirement 2(3)(e) – the Approved Provider ensures care and services are reviewed regularly for effectiveness, including when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.
* Requirement 3(3)(a) –the Approved Provider ensures each consumer gets safe and effective personal care and clinical care that is best practice, tailored to their needs and optimises their health and well-being. This includes for hygiene care.
* Requirement 3(3)(b) – the Approved Provider ensures high impact and high prevalence risks are managed, including documenting of relevant actions taken to mitigate risks.
* Requirement 6(3)(c) – the Approved Provider ensures feedback and complaints are acknowledged and responded to in a timely manner.
* Requirement 7(3)(a) – the Approved Provider ensures the workforce is planned and deployed to enable the delivery and management of safe and quality care and services. This includes rostering sufficient staff for consumers to receive personal care in line with their needs and preferences.
* Requirement 7(3)(d) – the Approved Provider ensures the workforce is recruited, trained, equipped and supported to deliver safe and quality care, including that mandatory training is completed.
* Requirement 8(3)(a) – the Approved Provider ensures consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Requirement 8(3)(c) – the Approved Provider ensures effective organisation wide governance systems, particularly relating to continuous improvement, feedback and complaints, workforce governance, and regulatory compliance.

# Standard 1

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| Consumer dignity and choice | | Compliant |
| 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 considered they were treated well and were respected. Staff were observed to be respectful in their interactions.

Consumers said their cultural needs were being met and the services provided were individualised and considerate of their identity. Staff had knowledge of consumers as individuals and were aware of their cultural needs. Care plans reflected consumers’ cultural requirements.

Overall consumers said they were able to make decisions about those who are involved in their care and they were supported to maintain relationships of choice. Staff were observed to be offering choices to consumers.

Consumers said they were supported to do things that involve risk. Staff described how they identify, mitigate and minimise risk, in line with strategies listed in care planning documentation.

Consumers confirmed they have the information they need to make choices about their care. Staff described how they communicate information in an inclusive and individualised way to support consumer choice.

Consumers confirmed their privacy and dignity was upheld. Staff were observed knocking on doors, awaiting responses and closing doors when providing care. Staff described how they maintain confidentiality.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-Compliant |
| 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. | Non-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. | Non-compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.

* 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.

The Assessment Team recommended the following requirement was not met:

* 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.

I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the Approved Provider’s response of 20 September 2022. I have found the service non-compliant with requirements (3)(c) and (3)(e) and compliant with requirement (3)(d).

* Regarding requirement 2(3)(c)

Consumers and their representatives stated they have minimal involvement in care planning, assessments or case conferences. Care planning documents did not demonstrate consumers or their representatives were involved in 3-monthly reviews.

The Approved Provider disagreed with the Assessment Team’s findings. They provided evidence of communications to consumers and their representatives regarding the case conferencing process. They described further communications issued following the Site Audit to engage with consumers and representatives regarding care planning. They gave evidence of a number of case conferences occurring following the Site Audit.

Two separate named consumers’ representatives said they have minimal involvement in care planning, and could not recall a case conference. Care planning documents reflected the prior case conference occurred more than 12 months prior, and the representatives were not involved in 3-monthly reviews. I have considered this as evidence of non-compliance with this requirement.

A named consumer said they were not involved, however they stated they were satisfied with their care plan. I have not considered this as evidence of non-compliance.

One named consumer who had recently moved to the service was unaware of assessment and care planning. The Approved Provider said the consumer’s representative was involved. Verifying information was not supplied to evidence this so I have not relied on this evidence in determining non-compliance.

While I am satisfied the service had general communication with consumers and their representatives about care planning, I have placed weight on consumer and representative feedback, and the care planning documents reflecting infrequent or inconsistent involvement. The further improvements implemented by the Approved Provider will take time to show effectiveness.

At the time of the Site Audit, care planning was not based on an ongoing partnership with consumers and others that wish to be involved. Therefore, I find requirement 2(3)(c) is non-compliant.

* Regarding requirement 2(3)(e)

Consumers and their representatives expressed dissatisfaction that personal and clinical care were not reviewed regularly for effectiveness in relation to skin integrity, continence care, hygiene and complex care needs. While the service has systems and processes to conduct reviews, changes were not consistently considered or documented. At the time of the Site Audit it was identified reviews were delayed due to staff shortages. This has been further considered under Quality Standard 3 requirement (3)(a) and Quality Standard 7 requirement (3)(a).

The Approved Provider acknowledged the feedback and described improvement actions taken following the Site Audit. This included additional staffing resources, discussions with consumers and their representatives, sourcing additional equipment and reviewing effectiveness of the strategies.

A named consumer’s charting was not being consistently completed. Despite these deficits, staff demonstrated awareness of the consumer’s needs.

A further named consumer’s dietary preferences were not updated following a review and hygiene charting was not consistently completed. Staff said insufficient time was available to complete charting.

A further named consumer previously required a medical device, however limited information about this was available in their care plan to guide staff in delivery of care. The care plan for a further medical condition was not updated for 12 months and further concerns are considered at requirement 3(3)(a). An additional medical condition had been reviewed by a specialist, however care planning documents did not show whether the directives were followed. Staff acknowledged the documentation deficits.

The Approved Provider’s changes will take time to demonstrate effectiveness. At the time of the Site Audit, consumers’ care plans were not consistently reflecting their current health needs. The service did not demonstrate care and services were being regularly reviewed for effectiveness, or that the relevant information was documented.

Therefore, I find requirement 2(3)(e) is non-compliant.

* Regarding requirement 2(3)(d)

While staff said the outcomes of assessment and planning are communicated, consumers and their representatives were not clear what a care plan is and did not have a copy or have awareness of how to access the document.

The Approved Provider referred to the communication that occurred with consumers and their representatives regarding care planning processes. While I am satisfied communication occurred prior to the Site Audit, I consider this was not fully effective due to the ongoing confusion from consumers and their representatives.

As there was no substantial impact brought forward as a result of the confusion, and further communication occurred with the consumers and representatives, I am satisfied overall outcomes of assessment and planning are communicated and are readily available.

Therefore, I find requirement 2(3)(d) is compliant.

I am satisfied the remaining 2 requirements of Quality Standard 2 are compliant.

Assessment and care planning processes are in place to inform the delivery of safe and effective care. Applicable risks are considered. Care planning documentation shows consumers, their representatives, medical officers and allied health practitioners are involved in the process.

Consumers and their representatives were satisfied with the assessment and planning process. Staff demonstrated understanding of consumers’ individual care needs. Overall care planning documents detail consumers’ current needs, goals and preferences, including advance care planning, and end of life wishes.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Non-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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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. Effective management of high impact or high prevalence risks associated with the care of each consumer.

I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the Approved Provider’s response of 20 September 2022.

* Regarding requirement 3(3)(a)

The Site Audit report reflected negative feedback from consumers and their representatives, who considered personal hygiene and continence care was not delivered in line with consumers’ needs and preferences to support their health and wellbeing. Staff considered they did not have time to provide best practice and tailored care. This has been further considered under Quality Standard 7 requirement (3)(a).

One named consumer’s representative said the consumer does not receive hygiene care in line with their needs and preferences, which was also reflected in care planning documents. Staff acknowledged the consumer did not receive care consistent with their preferences and the documentation deficits.

A further named consumer’s representative said the consumer does not receive preferred personal and hygiene care. Staff said they could not consistently provide care aligned with the consumer’s needs and preferences due to staff shortages.

A further named consumer and their representative gave examples of inadequate personal and hygiene care, also attributed to reduced staffing levels.

Regarding a fourth named consumer whose care documents lacked consistent charting relating to management of their clinical care, staff acknowledged deficits in the documentation and attributed this to workloads. As the consumer’s care documents were not updated, it was unclear whether they received suitable clinical care consistent with relevant directives.

The Approved Provider acknowledged the deficits and described action taken following the Site Audit, including additional staff being rostered, purchase of additional equipment to support hygiene care delivery, further meetings with staff and regular review of actions to assess suitability. While these actions are appropriate, as they were not in place at the time of the Site Audit they require time to demonstrate effectiveness.

Overall consumers did not receive effective personal and clinical care that is best practice, tailored and optimal. Therefore, I find requirement 3(3)(a) is non-compliant.

* Regarding requirement 3(3)(b)

The Assessment Team considered the service did not demonstrate effective management of high impact and high prevalence risks. Consumers’ charts were not completed according to the relevant frequency for clinical care issues.

Regarding one named consumer subject to restrictions, charting was incomplete and there were no notes regarding monitoring of the consumer’s condition. Although the consumer’s representative and medical officer gave consent for the consumer to exceed the restriction, due to staff feedback regarding them being unable to monitor the consumer’s condition, I am not satisfied the risks were suitably managed for the consumer.

Regarding a further named consumer who was to receive pain management and pressure area care, charting was incomplete and there was some conflicting information documented regarding care needs.

The Approved Provider said a clinical risk register is maintained and regularly reviewed and updated. They said ongoing monitoring of completion of documentation and charting will occur. While action was taken during and after the Site Audit to address the deficits, this requires time to demonstrate effectiveness.

As there were deficits in the documentation for the named consumers, I am unable to evaluate whether consumers were receiving care that suitably managed the relevant high impact and high prevalence risks. As such, I consider the examples are reflective of non-compliance with this requirement.

Overall the service did not demonstrate effective management of high impact and high prevalence risks. Therefore, I find requirement 3(3)(b) is non-compliant.

I am satisfied the remaining 5 requirements of Quality Standard 3 are compliant.

Care planning documents reflected consumers received end of life care consistent with their preferences, and their comfort was maximised.

Staff described how they recognise and respond to changes or deterioration, including referring consumers to other providers or transferring to hospital. Progress notes reflected staff monitor consumers following incidents, notify representatives and other providers, and take action to address the consumer’s condition.

Overall information was shared between staff and other organisations and providers of care. Staff said changes are documented in handover documents.

Consumers and their representatives said timely and appropriate referrals occur to other providers. Care planning documents reflected the outcome of referrals is documented.

The service has policies and procedures regarding infection control and outbreak management. Staff described how they prevent and control infection and take steps to promote appropriate antibiotic use.

# Standard 4

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| Services and supports for daily living | | Compliant |
| 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

The Assessment Team recommended the following requirement was not met:

* 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.

The Assessment Team brought forward comments from 6 named consumers and representatives who were dissatisfied with the activities provided or uncertain if the consumer was attending relevant activities. Staff said activities are reduced over the weekend due to staffing levels and they did not have time to engage in detail with consumers one-on-one. Activity charts reflected low consumer attendance.

The Approved Provider disagreed with the Assessment Team’s findings, and said ongoing feedback opportunities are available for consumers and representatives to raise issues regarding activities. The Approved Provider said some consumers decline to participate in some activities, as is their choice, and acknowledged this could be better reflected in their care documents. They gave evidence of engagement at consumer meetings prior to the Site Audit, and follow up occurred with consumers after the Site Audit to obtain feedback regarding activity interests and preferences.

While consumers and their representatives provided negative feedback, the information given by the Approved Provider supported the service was engaged with consumers on an ongoing basis to evaluate their satisfaction with the activity program. They demonstrated responsiveness to consumers’ feedback and gave evidence that generally consumers said they were satisfied with the activities.

Overall I am satisfied the service was providing safe and effective services and supports for daily living, and making efforts to meet consumers’ needs, preferences and optimise their independence and quality of life. Therefore, I find requirement 4(3)(a) is compliant.

I am satisfied the remaining 6 requirements of Quality Standard 4 are compliant.

Consumers described services and supports that promoted emotional, spiritual and psychological wellbeing, such as attending weekly church services. Staff gave examples of how they support consumers’ wellbeing and facilitate them to attend church. Care plans reflected consumers’ individualised emotional support strategies.

Consumers said they felt supported to participate in activities within the service and outside in the community as they choose, and maintain connections. Care plans reflected activities and people important to consumers.

Consumers said staff know their needs and information is communicated. Staff described how they are aware of changes such as via handover, the care management system and dietary requirement documents.

Care plans reflected consumers are referred to other services as relevant, including for lifestyle supports. Staff said they engage external organisations and support services to supplement the lifestyle activities, such as art, music and pet therapy.

Consumers said the service provides meals which are varied and were satisfied with the quality and quantity of food. Monthly food focus group meetings reflected menu suggestions were welcome and changes were made in line with consumer feedback.

Consumers said they felt safe when using equipment, it was accessible and suitable for their daily living needs. Equipment was observed to be clean and well-maintained.

# Standard 5

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| Organisation’s service environment | | Compliant |
| 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 and their representatives stated they felt welcome in the service environment, found it easy to navigate, and they had a sense of belonging. The service was observed to be spacious, with accessible outdoor areas for consumers.

Consumers said the service environment is clean and comfortable. Communal areas were observed to be clean, tidy and walkways were free of obstructions. Staff conduct cleaning in accordance with a schedule, and preventative and reactionary maintenance occurs.

Furniture, fittings and equipment throughout the service were clean, safe, well maintained and suitable for consumers. Staff said they have access to safe and well-maintained equipment to support consumer needs. Staff described how they clean equipment after use and said maintenance is completed promptly when needed.

**Standard 6**

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| Feedback and complaints | | Non-compliant |
| 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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team recommended the following requirement was not met:

Feedback and complaints are reviewed and used to improve the quality of care and services.

I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the Approved Provider’s response of 20 September 2022. I have found the service and non-compliant with (3)(c) and compliant with requirement (3)(d).

* Regarding requirement 6(3)(c)

Staff described complaints they received and described how they practice open disclosure. However, the Site Audit report identified actions were not always taken following feedback and there had been no accurate register of complaints and feedback. Examples were brought forward regarding complaints without a sufficient response, including 2 complaints from one named consumer’s representative regarding staffing concerns.

The Approved Provider disagreed with the Assessment Team’s findings. They gave evidence of logging the complaints received from the named consumer’s representative, though this occurred following the Site Audit.

The Approved Provider did not give evidence regarding the follow up taken in relation to the representative’s complaint. As the complaint was not dealt with in a timely manner, I consider this is evidence of non-compliance with this requirement.

Overall the service did not consistently demonstrate appropriate and timely action was taken in response to complaints. Therefore, I find requirement 6(3)(c) is non-compliant.

* Regarding requirement 6(3)(d)

While the service has a system for recording complaints and feedback, information was not consistently entered into the system from March 2022. Deficits in recording complaints were identified prior to the Site Audit and actions were planned to support staff to consistently record complaints.

The Approved Provider stated the service was taking action to monitor consumer and representative feedback while changes were implemented, including conducting interviews to obtain feedback. They said feedback and complaint information is collected from various sources and included in the service’s plan for continuous improvement as relevant.

The timeliness of the service’s system deficit has been considered in Quality Standard 8 requirement (3)(c).

Insufficient evidence was brought forward to support the service was not reviewing and using feedback and complaints to improve the quality of care and services. Actions were implemented prior to the Site Audit to address deficits. Therefore, I find requirement 6(3)(d) is compliant.

I am satisfied the remaining 2 requirements of Quality Standard 6 are compliant.

Consumers and their representatives described making complaints, and said they were comfortable approaching staff with complaints. Staff described how they support consumers requiring assistance, such as using interpreter services and monitoring non-verbal behaviour. Feedback forms and secured boxes are available. Posters gave information about external complaints and advocacy services.

**Standard 7**

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| Human resources | | Non-compliant |
| 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.
* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team recommended the following requirement was not met:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken

I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the Approved Provider’s response of 20 September 2022. I have found the service non-compliant with 7(3)(a) and 7(3)(d), and compliant with requirement 7(3)(e).

* Regarding requirement 7(3)(a)

The Site Audit Report reflected negative feedback from consumers, their representatives and staff regarding the number of staff available to provide relevant care to consumers. Staff said rostering changes impacted their ability to deliver person centred care, and they had to prioritise their work meaning some consumers did not receive personal care in line with their needs and preferences. At the time of the Site Audit, management disagreed with the feedback regarding the rostering and said plans were in place to recruit additional permanent staff and reduce the number of agency staff utilised.

The Approved Provider did not agree with the Assessment Team’s findings. They stated rostering was carefully planned and changes did not result in a decrease to the quality of care and services. They described the changes made to the roster to better support clinical care. They said where shifts were unable to be replaced prior to the Site Audit, sufficient staff were available to deliver care.

I have placed weight on the high volume of negative feedback from consumers, their representatives and staff, including the comments and evidence that consumers were not receiving personal care in line with their needs and preferences, and care documentation was not being routinely updated regarding personal and clinical care.

While I accept the Approved Provider was taking action to address staffing concerns prior to and following the Site Audit, these actions have not been fully implemented and will take time to demonstrate effectiveness.

Overall the service did not demonstrate effective workforce planning, and the number and mix of staff deployed did not facilitate provision of safe and quality personal and clinical care. Therefore, I find this requirement is non-compliant.

* Regarding requirement 7(3)(d)

The Assessment Team identified deficiencies in the service’s training compliance. Although the service had a number of mandatory training modules, staff were not completing them and the training system recorded low completion rates for modules relevant to staff duties. Some staff described wanting to do additional training, or agency staff said they were not informed of training.

At the time of the Site Audit management described plans in place to ensure training was completed, including clear instruction to staff and scheduling the training. The Approved Provider confirmed the actions taken to enable staff to complete the training. They said ongoing monitoring occurs to ensure staff can be followed up when training is due.

While I am satisfied the Approved Provider was taking appropriate action, as it was not implemented sufficiently prior to the Site Audit I do not consider it was sufficient to demonstrate compliance with this requirement.

Due to delays in staff completing required training, the service did not demonstrate the workforce was trained, equipped and supported to deliver the outcomes required. Therefore, I find requirement 7(3)(d) is non-compliant.

* Regarding requirement 7(3)(e)

The Site Audit Report noted a quarter of staff appraisals were outstanding at the time of the Site Audit. The Assessment Team considered there was not a suitable appraisal process in place. Some staff described not receiving appraisals, or not receiving suitable feedback.

The Approved Provider disagreed with the Assessment Team’s findings. They stated staff appraisals that were outstanding were not due, and gave supporting documents to evidence this. They issued a memorandum to staff following the Site Audit explaining the review process.

I accept the staff feedback as reflective of staff experience. No further negative impact was brought forward as a result of delays, or perceived delays or deficits, in performance appraisals and no staff competency concerns were brought forward in the Site Audit Report.

Overall the service demonstrated regular assessment, monitoring and review of staff performance occurs. Therefore, I find requirement 7(3)(e) is compliant.

I am satisfied the remaining 2 requirements of Quality Standard 7 are compliant.

Consumers and their representatives confirmed staff were kind and caring, and treated consumers with respect. Staff were observed to be kind, caring and respectful to consumers and each other.

Staff are competent and have the qualifications and knowledge to effectively perform their roles. Position descriptions detail qualifications, and registrations are reviewed. Staff are supported to complete qualifications.

**Standard 8**

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| Organisational governance | | Non-compliant |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-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. | Non-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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* 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.

The Assessment Team recommended the following requirements were not met:

* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* 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.

I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the Approved Provider’s response of 20 September 2022. I have found the service non-compliant with 8(3)(a) and 8(3)(c), and compliant with requirements 8(3)(b) and 8(3)(d).

* Regarding requirement 8(3)(a)

The Assessment Team brought forward negative feedback from consumers and their representatives regarding their involvement in development, delivery and evaluation of care and services. This is also reflected in non-compliance at Quality Standards 2 and 6.

The Approved Provider gave evidence of efforts to engage with consumers and their representatives regarding care planning, delivery and evaluation. They described ongoing monitoring processes and further actions being implemented to better engage with consumers and their representatives. This includes recording of feedback, reporting and consultation.

I have placed weight on the negative feedback from consumers and their representatives regarding lack of involvement and inaction regarding feedback and complaints. At the time of the Site Audit, the service did not demonstrate consumers are supported and engaged in development and evaluation of care and services. Therefore, I find requirement 8(3)(a) is non-compliant.

* Regarding requirement 8(3)(c)

The Site Audit Report reflected the service had effective systems for information management and financial governance. However, deficits were brought forward for continuous improvement, feedback and complaints, workforce governance and regulatory compliance.

Regarding continuous improvement and complaints, the service had a plan for continuous improvement showing recent updates, however the Assessment Team identified deficits in addressing complaint data shortfalls and staffing concerns. The Approved Provider acknowledged the issues regarding the complaint data. They said a communication plan is in place regarding staffing concerns. While I am satisfied these actions are suitable, as the systems were not operating effectively prior to the Site Audit and there were delays in the service identifying the deficits, I have considered this as evidence supporting non-compliance with this requirement.

Regarding workforce governance, the Assessment Team considered the service had not sufficiently managed staffing levels and training needs. The Approved Provider described improvements to training completion rates since the Site Audit, and said ongoing monitoring of training completion occurs. Further to the findings at Quality Standard 7 requirements (3)(a) and (3)(d), based on consumer and staff feedback I consider the service was not sufficiently identifying and addressing the deficits in workforce governance prior to the Site Audit. Therefore, I have considered this evidence as supporting non-compliance with this requirement.

Regarding regulatory compliance, the Assessment Team brought forward a delay in reporting a suspected neglect incident, however limited detail was provided. The Approved Provider acknowledged the deficits and described updates to policies and procedures and further training delivered to staff regarding the Serious Incident Response Scheme. While I am satisfied the Approved Provider’s actions are suitable, as there was a deficit prior to the Site Audit I consider this evidence supports non-compliance with this requirement.

Some of the organisation’s governance systems were not operating effectively to pre-emptively identify and address deficiencies and the service failed to demonstrate sustainable changes were implemented prior to the Site Audit, specifically in relation to continuous improvement, feedback and complaints, workforce governance and regulatory compliance. Therefore, I find this requirement is non-compliant.

* Regarding requirement 8(3)(b)

The Assessment Team considered the organisation’s governing body did not promote a culture of quality care and did not demonstrate accountability. Examples given included changes to rostering despite negative staff feedback, deficits in complaint and incident reporting processes and workplace culture concerns.

The Approved Provider disagreed with the Assessment Team’s findings. They said deficits in reporting were proactively identified and further reporting mechanisms were in place, and gave further context for rostering decisions. They described additional actions in place to maintain effective reporting systems.

I am satisfied with the Approved Provider’s response and consider overall the governing body has oversight of the service’s performance and is accountable for promoting a culture of safe, inclusive and quality care and services.

Therefore, I find this requirement is compliant.

* Regarding requirement 8(3)(d)

The Assessment Team considered the service did not demonstrate effective risk management systems and practices. They brought forward an incident example, also referenced at requirement 8(3)(c), and deficits in staff training. As the same examples were used to determine non-compliance at that requirement and requirement 7(3)(d) I do not consider it suitable to also rely on that evidence in determining non-compliance with this requirement.

The Approved Provider supplied evidence of regular clinical staff meetings where risks are reviewed and risk management strategies are discussed. Based on the evidence supplied I am satisfied the Approved Provider has suitable systems, and was generally implementing suitable processes, to manage risk, prevent incidents and support consumers to live their best lives. Therefore, I find requirement 8(3)(d) is compliant.

I am satisfied the remaining requirement of Quality Standard 8 is compliant.

The service has a documented clinical governance framework, which includes policies regarding antimicrobial stewardship, minimising the use of restrictive practices and applying open disclosure. Staff described how they apply the policies in their work.

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-2)