Performance

Report

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| Name of service: | Mercy Place Albury |
| Service address: | 578 Poole Street ALBURY NSW 2640 |
| Commission ID: | 2667 |
| Approved provider: | Mercy Aged and Community Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 June 2023 to 22 June 2023 |
| Performance report date: | 10 August 2023 |

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 Mercy Place Albury (**the service**) has been prepared by G Cherry, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others
* the provider’s response to the assessment team’s report received 18 July 2023
* Performance Report dated 31 August 2022

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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| Consumer dignity and choice | |  |
| 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 |

Findings

The Quality Standard was not fully assessed. One of six requirements was assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in requirement 1(3)(c) after a site assessment conducted 5-8 July 2022. Previously the service did not demonstrate effective systems to ensure consumers receive support to exercise choice/independence and make decisions relating to delivery of care and services. In response the service has worked with staff to ensure an understanding of consumers rights in decision making.

During this assessment contact information was gathered through interviews, observations, and document review. Some sampled consumers and representatives consider consumers are supported to make decisions relating to their care, giving examples of satisfaction. One consumer expressed dissatisfaction a request to attend exercise class/additional physiotherapy and one representative’s requests for additional physiotherapy were not supported.

In their response the approved provider supplied evidence multiple physiotherapy reviews for one consumer, most recently in response to evidence in the assessment contact report, noting one missed attendance at exercise class and instigated additional physiotherapy review for another. In consideration of compliance, I am swayed by positive feedback received from most consumers/representatives and evidence supplied by the approved provider. I find requirement 1(3)(c) is compliant.

# 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

All requirements of this Quality Standard were assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in all 5 requirements after a site assessment conducted 5-8 July 2022.

Requirement 2(3)(a)

Previously the service did not demonstrate systems to ensure assessment and planning takes into consideration risks to consumers health/well-being to inform safe/effective care. Actions implemented since the assessment conducted 21-22 June 2023, include provision of clinical staff education regarding identification of risks and amending care plans to reflect current details. Management review of care plans and relevant documentation for those consumers identified at risk plus appointment of an additional registered nurse to review documentation/processes.

During this assessment contact information was gathered through interviews, observations, and document review. Policies and procedures guide staff in assessment and care planning requirements. A suite of risk assessments are completed during entry, via routine reviews, and revised when care needs change. Documentation for sampled consumers demonstrate assessments identify risks such as changed behaviours, mobility/falls, skin integrity/pressure injuries and nutrition, including interventions/strategies to minimise risk. Summary care plans (accessible to consumers/representatives) provide staff with information for care provision. I find requirement 2(3)(a) is compliant.

Requirement 2(3)(b)

Previously the service did not demonstrate effective systems of assessment/planning consistently identifies/addresses all consumers’ current needs/goals/preferences. Actions implemented since the assessment conducted 21-22 June 2023, include reviewing care planning documentation to ensure currency of and provision of staff education regarding assessment/care plan development.

During this assessment contact information was gathered through interviews, observations, and document review. Some sampled consumers care planning documentation includes consumer goals/preferences regarding personal cares and advanced care directives. However, the assessment team note care plans did not consistently contain details of consumer’s current needs/goals/preferences. A review of five consumers documentation notes lack of details relating to palliative care needs for one consumer, details of recent dietitian review/directives for another, directives relating to recent medication review for another, swallowing risks for two consumers and details of diabetes management not included in summary care plan guidance for another.

In their response, the approved provider supplied evidence of recent review/updating of advance care directive/ palliative care planning in a timely manner, alternative locations of information relating to diabetes, awaiting receipt of dietitian report/ medication review for two consumers, appropriate review of swallowing risks and queried accuracy of evidence bought forward for one named consumer. In consideration of compliance, I am swayed by the approved provider’s evidence supporting assessment and planning identifies/addresses consumers current needs/goals/preferences and documentation update occurs in an appropriate/relevant timeframe. I find requirement 2(3)(b) is compliant.

Requirement 2(3)(c)

Previously the service did not demonstrate effective systems of assessment/care planning is based on ongoing partnership with consumers and others they wish to involve. Actions implemented since the assessment conducted 21-22 June 2023, include ensuring clinical staff awareness of requirement to record/action information/directives received from external organisations and completion of audit by an external provider/subsequent implementation of recommendations.

During this assessment contact information was gathered through interviews, observations, and document review. Interviewed management and registered staff explain methods of engaging consumers/representatives in care review at three monthly intervals and/or when a change in needs occurs. Registered nurses have responsibility in completing care reviews/conferences with consumers and representatives. While some consumer/representatives consider they partner in care planning not all those sampled noted involvement. Two representatives’ express satisfaction of regular discussions/updates relating to aspects of care delivery, including concerns, changes to care, and/or when incidents occur; one representative expressed no involvement/consultation in care planning. Documentation detail referrals and reviews by medical officers, medical specialists, physiotherapists, podiatrists, allied health, and wound care specialists.

In their response, the approved provider supplied evidence of recent inclusion of consumer/representatives in assessment/care planning discussions. In consideration of compliance, I am swayed by the approved provider’s evidence supporting effective processes. I find requirement 2(3)(c) is compliant.

Requirement 2(3)(d)

Previously the service did not demonstrate systems outcomes of assessment/care planning are effectively communicated to consumers/representatives and/or documented in care plans to guide staff care provision. Actions implemented since the assessment conducted 21-22 June 2023, include communicating with clinical staff the need to involve consumers/representative in ‘resident of the day’ processes and ad-hoc care evaluations, including documentation in care consultation records and distribution of written communication regarding the ‘resident of the day’ process/schedule.

During this assessment contact information was gathered through interviews, observations, and document review. Sampled consumers and representatives express mixed feedback regarding communication of assessment/care planning outcomes and accessing care plan documentation. Several representatives advise being involved in discussions and awareness or receipt of documentation however one representative expressed lack of involvement/receipt of care plan.

In their response, the approved provider supplied evidence of recent inclusion of consumers/representatives in assessment/care planning discussions, plus supporting evidence relating to feedback received from one representative.

In consideration of compliance, while acknowledging feedback from consumers/representatives I am swayed by the approved provider’s evidence of processes to support this process and the volume of satisfaction received from consumers/representatives relating to care provision. I find requirement 2(3)(d) is compliant.

Requirement 2(3)(e)

Previously the service did not demonstrate review of care/services when circumstances change and/or incidents impact consumer’s needs/preferences. Actions implemented since the assessment conducted 21-22 June 2023, include provision of education to clinical staff relating to identification/documentation of risks, assessment/care planning, and identification of clinical deterioration.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate incidents are reported/documented and managed as they occur including representative and medical officer notification/ referral for review. The assessment team state care provision is not consistently reviewed for effectiveness and/or strategies not consistently recorded to address new risks and/or potential recurrence.

In their response, the approved provider supplied details of Incident Management System reports monitoring statistics (including incident completion), note daily clinical leadership meetings to discuss/review incidents, use of investigation tools which guide identification of potential causal factors, trialling of strategies for individual consumers, data analysis and trending evidence. In consideration of compliance, I am swayed by the approved provider’s evidence of systems/processes to support review and responsiveness when incidents impact consumer’s needs/preferences. I find requirement 2(3)(e) is compliant.

# 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. | 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 Quality Standard was not fully assessed. Five requirements were assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in requirements 3(3)(a), 3(3)(b), 3(3)(e), 3(3)(f) and 3(3)(g) after a site assessment conducted 5-8 July 2022.

Requirement 3(3)(a)

Previously the service did not demonstrate systems to ensure consumers receive safe/effective personal and clinical care as per best practice guidelines and tailored to consumers’ needs particularly in relation to pain management, skin integrity/pressure injury care and wound management. Actions implemented since the assessment conducted 21-22 June 2023, include:

* Clinical meeting held to discuss clinical responsibilities relating to wound management; wound consultant reviewed all active wounds, review wound specialist referral process ensuring clinical staff awareness, all clinical and care staff completed mandatory education relating to skin integrity/pressure injury/wound management; ensured congruency/accuracy of pressure care within electronic system
* all clinical and care staff completed mandatory education relating to pain management
* provision of intensive education on documentation needed for all restrictive practices; ensured all consumer’s restrictive practice had correlating documentation, including psychotropic medication register/documentation to ensure currency of information; provision of education to clinical and care staff regarding use of restrictive practices, including trialling alternate strategies and documentation methods
* reiterated process for clinical manager review of progress notes; responsibility to conduct clinical meetings provide education/mentorship/leadership relating to communication skills
* review of handover process for clinical/care staff including process for consumer-related equipment maintenance

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate effective systems to ensure consumers receive safe/effective personal and clinical care tailored to their needs/preferences aligned with principles of best practice. Sampled consumers/representatives consider staff to be kind and caring, expressing satisfaction consumers receive care and services appropriate to their needs/preferences; positive feedback relates to pain management. Interviewed staff demonstrate awareness of how assessment/care planning processes result in safe/effective care, giving specific examples relating to sampled consumers. Documentation reflect appropriate management of skin integrity/wound management for three sampled consumers, including identification/response when deterioration occurred.

Pain assessments/monitoring/medications/evaluation and referral to medical officer/allied health specialists resulted in appropriate management of pain via non-pharmacological and medication based on individual needs for two sampled consumers. Documentation review detail appropriate documentation/management of psychotropic medication as per legislative requirements however the assessment team note a time delay in obtaining consent upon review and requirements do not change. In their response the approved provider detail processes occur to maintain consumers’ needs as per internal legal advice.

In consideration of compliance, I am swayed by the evidence bought forward by the assessment team and the approved provider’s evidence of effective systems/processes. I find requirement 3(3)(a) is compliant.

Requirement 3(3)(b)

Previously the service did not demonstrate effective management of high impact/prevalence risks such as skin integrity/wound management, catheter care, falls prevention and pain management. Actions implemented since the assessment conducted 21-22 June 2023, include:

* a clinical meeting held to discuss clinical responsibilities relating to wound management; full body skin inspections for consumers (after gaining consent) and subsequent completion of skin assessment/care plans; wound consultant reviewed current wounds; clinical and care staff completed mandatory education relating to skin integrity/pressure injury and wound management; clinical and care staff provided wound management education relating to consumer’s current wound care needs; ensured congruency/currency of pressure care detailed within electronic system; reviewed process for wound specialist referral ensuring clinical staff awareness of required processes, and implemented a weekly wound audit review process.

During this assessment contact information was gathered through interviews, observations, and document review. Organisational management advise identification of high impact/prevalence risks associated with each consumer’s care occurs via assessment/care planning processes. Sampled consumers/representatives mostly express positive feedback relating to consumer’s clinical care and management of individual risk, giving examples of equipment to support positive outcomes. Management note falls, pressure injuries and changed behaviours to be high impact/prevalence risk associated with the current consumer cohort. Via review of documentation the assessment team bought forward deficits in relation to management of risks for sampled consumers. For one consumer experiencing several unobserved falls, documentation does not demonstrate neurological observations conducted as per principles of best practice and/or organisational requirements on one occasion. In their response while acknowledging the first set of observations not conducting within timeframe (noting the consumer slept) observations commenced as soon the deficit was identified and continued as per organisational requirements, noting no negative consumer outcome.

Most interviewed care staff demonstrate knowledge of consumer’s behavioural needs and some strategies to address changed behaviours. Via document review for two consumers the assessment team note limited individualised triggers and/or strategies to guide staff in care provision, staff not consistently recording behaviours and/or evidence to support behaviours are regularly monitored to ensure the effectiveness of strategies. Document review for another consumer details staff recording frequency of behavioural incidents and effectiveness of interventions in differing documentation. In their response, while the approved provider acknowledge documenting in differing areas is not optimal, it is noted no negative consumer outcome as a result. Document review for two consumer’s risk assessments relating to episodes of choking the assessment team note referral to a speech pathologist for one however did not demonstrate a follow-up risk assessment conducted nor consideration of risk and/or mitigating strategies for another. Document review and staff interviews resulting in conflicting information relation to one consumer’s complex care needs.

In their response, the approved provider supplied details of Incident Management System reports monitoring statistics (including incident completion), note daily clinical leadership meetings to discuss/review incidents, use of investigation tools which guide identification of potential causal factors, trialling of strategies for individual consumers, data analysis and trending evidence.

In consideration of compliance, I am swayed by the approved provider’s evidence of systems/processes to support management of high impact/prevalence risks associated with consumer care. I find requirement 3(3)(b) is compliant.

Requirement 3(3)(e)

Previously the service did not demonstrate systems to ensure information relating to consumers’ needs/preferences is effectively communicated to those providing care. Actions implemented since the assessment conducted 21-22 June 2023, include review of consumer assessment/care planning documentation and handover/information transfer process between clinical and care staff. The service identified knowledge deficits regarding documentation requirements (including electronic care management system) in relation to complex care needs.

During this assessment contact information was gathered through interviews, observations, and document review. The assessment team note deficits in accurate information being documented/ communicated with those where care responsibility is shared; in particular relating to changes in care needs and/or post specialist review, however the approved provider supplied evidence of information in alternative areas and/or non-receipt of information due to referral timeframe. One representative expressed dissatisfaction in relation to lack of timely responses/communication with clinical staff when issues are raised and/or contact when changes occur. Management note delay and investigation is occurring.

In consideration of compliance, I am swayed by the approved provider’s evidence of systems/processes to ensure information is communicated to those where responsibility for care is shared. I find requirement 3(3)(e) is compliant.

Requirement 3(3)(f)

Previously the service did not demonstrate systems to ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services consistently occurs; in particular relating to wound care specialists and dietitian. Actions implemented since the assessment conducted 21-22 June 2023, include provision of staff education and review of referrals process to dietitian/external specialists.

During this assessment contact information was gathered through interviews, observations, and document review. Care planning documents for most sampled consumers detail referral to allied health professionals, medical and other specialists ensuring consumers/representative's preferences are considered. Senior clinical staff advised of regular visits by multiple allied health specialists and/or when consumer’s needs change. Examples of referrals and subsequent inclusion of directives in care planning documentation to guide staff in care delivery. I find requirement 3(3)(f) is compliant.

Requirement 3(3)(g)

Previously the service did not demonstrate systems and/or strategies to minimise infection related risks. Actions implemented since the assessment conducted 21-22 June 2023, include assessment/care plans reviewed to ensure accuracy and currency; provision of education to clinical staff; all staff education relating to organisation screening processes/vaccination requirements and clinical staff education relating to management of complex cares.

During this assessment contact information was gathered through interviews, observations, and document review. Policies/procedures guide staff in relation to infection control requirements and regular review of an outbreak management plan. A registered nurse (Infection Prevention Control (IPC) and management monitor appropriate equipment stock and guide staff practice. A documented monitoring system ensures vaccination currency. Interviewed representatives consider staff adhere to appropriate hygiene practices and incidences of infection outbreaks well-managed. Staff demonstrate understanding of practices to prevent transfer of infections, registered staff demonstrate knowledge of antimicrobial stewardship, infection control precautionary requirements and use of antibiotics. Staff advise of education received and were observed performing appropriate hygiene practices. I find requirement 3(3)(g) is compliant.

# 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)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

The Quality Standard was not fully assessed. Two of seven requirements were assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in requirements 4(3)(a) and 4(3)(d) after a site assessment conducted 5-8 July 2022.

Requirement 4(3)(a)

Previously the service did not demonstrate systems ensure each consumer gets safe/effective services and supports for daily living which meet consumer’s needs/preferences. Actions have been implemented since the assessment conducted 21-22 June 2023, including implementation of a consumer forum (held each quarter) to enable consumers input into services/delivery of care; the manager of hotel services and lifestyle manager attend.

During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate effective methods of optimising consumer independence, well-being, and quality of life. Examples include labelling of clothing resulting in positive outcomes and a mini supermarket for consumer access. Sampled consumers express satisfaction with services received. I find requirement 4(3)(a) is compliant.

Requirement 4(3)(d)

Previously the service did not demonstrate effective systems to consumers information is communicated with those where responsibility is shared.

During this assessment contact information was gathered through interviews, observations, and document review. Interviewed staff demonstrate awareness of methods to ensure consumers’ needs/preferences are met, including dietary changes and communication with clinical staff. In consideration of compliance, I am swayed by evidence demonstrating methods supporting information transfer between staff. I find requirement 4(3)(d) is compliant.

# 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)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Quality Standard was not fully assessed. Three requirements were assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in requirements 6(3)(a), 6(3)(c) and 6(3)(d) after a site assessment conducted 5-8 July 2022.

Requirement 6(3)(a)

Previously the service did not demonstrate effective systems to encourage/support consumers/representatives in providing feedback and make complaints. Actions implemented since the assessment conducted 21-22 June 2023, include the service manager attending consumer meeting forums to identify feedback/complaints, and discusses methods of feedback provision. Plus, implementation of a consumer forum (held each quarter) to enable consumers input into services/delivery of care; the manager of hotel services and lifestyle manager attend.

During this assessment contact information was gathered through interviews, observations, and document review. Most sampled consumers/representatives consider they are supported to provide feedback however some disagree. Interviewed staff demonstrate how they would support consumers to provide feedback or if feedback was communicated to them including escalating issues of concern. The assessment team note not all recent feedback is documented, however management advised this occurs once issues are completed.

In their response, the approved provider supplied details of improvements implement as a result of feedback received. In consideration of compliance, I am swayed by the approved provider’s evidence of systems/processes to support/encourage/implement improvements resulting from feedback/complaints. I find requirement 6(3)(a) is compliant.

Requirement 6(3)(c)

Previously the service did not demonstrate effective systems to ensure appropriate action is taken in response to complaints and use of an open disclosure process when things go wrong. Actions implemented since the assessment conducted 21-22 June 2023, include ensuring acknowledgement of complaints as the arise. During this assessment contact information was gathered through interviews, observations, and document review. The service demonstrate methods utilised to enable consumer/representative feedback. Sampled consumers/representatives’ express satisfaction in relation to management’s responsiveness when issues are raised. I find requirement 6(3)(c) is compliant.

Requirement 6(3)(d)

Previously the service did not demonstrate effective systems ensure feedback and complaints are reviewed and used to improve quality of care and services.

During this assessment contact information was gathered through interviews, observations, and document review. Management demonstrate recent improvement examples including purchase of equipment in response to a recent incident and via external complaint processes. Mechanisms include surveys to ascertain consumers views, and forums for to enable consumer input into services/delivery of care where manager of hotel services and lifestyle attend.

In their response, the approved provider supplied details of improvements implement as a result of feedback received. In consideration of compliance, I am swayed by evidence of systems/processes to support/encourage/implement improvements resulting from feedback/complaints. I find requirement 6(3)(d) is compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(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 |

Findings

The Quality Standard was not fully assessed. Three requirements were assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in requirements 7(3)(a), 7(3)(c) and 7(3)(d) after a site assessment conducted 5-8 July 2022.

Requirement 7(3)(a)

Previously the service did not demonstrate a planned workforce enables management and of safe and quality care and services. Actions implemented since the assessment conducted 21-22 June 2023, include an intensive recruitment drive to fill permanent vacancies and increase casual staff pool, resulting in registered nurse rosters being filled and recruitment of multiple care staff.

During this assessment contact information was gathered through interviews, observations, and document review. Management explained processes to replace unplanned leave including pre-booking agency staff to ensure coverage. Management described current workforce number/skill mix noting methods trialled to ensure staff sufficiency and processes utilised by registered nurses in determining workforce allocations; for example, assigning staff in areas of familiarity of consumer’s needs. They advised a current recruitment process occurring. Most interviewed staff consider insufficient staffing numbers result in non-replacement of some unplanned leave, however explain methods utilised to meet consumer’s needs. Document review detail monitoring process to ensure staff respond to consumers’ needs in an acceptable timeframe. An ongoing organisational improvement action (and regular evaluation) includes comprehensive roster review, agency usage, training compliance and recruitment strategies. Feedback from sampled consumers consider staff to be gentle, respectful, and caring when attending to their needs, three noting diminished staffing at night.

In consideration of compliance, I am swayed by evidence the workforce is planned to enable delivery of care and services and volume of consumer satisfaction. I find requirement 7(3)(a) is compliant.

Requirement 7(3)(c)

Previously the service did not demonstrate a competent workforce have qualifications and knowledge to effectively perform their roles, particularly relating to wound care, medication management and complex clinical needs. Actions implemented since the assessment conducted 21-22 June 2023, include requirement for all staff to complete training relating to skin integrity/pressure injury/wound management, based on consumer cohort current needs.

During this assessment contact information was gathered through interviews, observations, and document review. Management explained processes to ensure staff qualifications and competency assessments relevant to their role, documentation review demonstrated completed competencies and staff demonstrated awareness of assessment processes to ensure skill requirements. Sampled consumers express satisfaction relating to care received from staff relating to complex care needs however two consumers express needing to remind some staff of their individual needs.

In consideration of compliance, I am swayed by evidence of systems to ensure workforce competence including qualifications and knowledge to effectively perform their roles and volume of consumer satisfaction. I find requirement 7(3)(c) is compliant.

Requirement 7(3)(d)

Previously the service did not demonstrate effective systems to ensure the workforce is trained, equipped, and supported to deliver outcomes required by the Quality Standards. Actions implemented since the assessment conducted 21-22 June 2023, include provision of training to existing care staff and extensive training to new care staff.

During this assessment contact information was gathered through interviews, observations, and document review. Processes ensure staff have appropriate education/ training relating to the Quality Standards to effectively perform their role. Sampled consumers/representatives consider staff are trained and competent to deliver required care. Annual skills and competency assessments are required for varying roles and provision of education/training is ongoing with a dedicated focus on completion when training completion rates are low. Staff describe responsibilities of their roles, acknowledge support received relating to education/training and documents detail how monitoring of qualifications, registrations, and competencies is conducted. The service is supported by an organisational human resources team for recruitment and onboarding/orientation processes. Monitoring of staff competency/skills is via information received through complaints, incidents, staff feedback and during performance management reviews; learnings, regulatory requirements are discussed via meeting forums.

In consideration of compliance, I am swayed by evidence of systems to ensure the workforce is recruited, trained, equipped, and supported to deliver the outcomes required Quality Standards and volume of consumer satisfaction. I find requirement 7(3)(d) is compliant.

# 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. | 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

All requirements of this Quality Standard were assessed and found compliant.

A decision was made on 31 August 2022 that the service was non-compliant in all 5 requirements after a site assessment conducted 5-8 July 2022.

Requirement 8(3)(a)

Previously the service did not demonstrate effective systems to ensure consumers and their representatives have opportunity for engagement in the development, delivery and evaluation of care and services. Actions implemented since the assessment conducted 21-22 June 2023, include re-establishment of regular consumer/representative meetings forums and newsletters.

During this assessment contact information was gathered through interviews, observations, and document review. A governing body representative explained organisational strategic requirements and systems to engage consumers in the design, delivery, and evaluation of services, giving examples of consumers inclusion/decision making in improvement activities. An organisational community advisory committee (CAC), and key governance committee provides oversight/strategic direction for consumer engagement, planning, design, and evaluation. Documentation detailing this process is on display. Most sampled consumers consider the service to be well run and improvement occur as a result of consumer input. I find requirement 8(3)(a) is compliant.

Requirement 8(3)(b)

Previously the service did not demonstrate the organisation’s governing body promotes (and is accountable) of a culture of safe, inclusive, quality care/services.

During this assessment contact information was gathered through interviews, observations, and document review. The organisation’s governing body promotes a culture of safe, inclusive care/services and the chief executive officer has accountability for delivery through engagement and implementation of changes via consumer feedback, incidents in this service and/or others within the organisation. The organisation’s code of conduct communicated to staff reflects values of compassion, hospitality, respect, innovation, stewardship, and teamwork. Behaviours. Accountability and assurance of compliance with the Quality Standards is achieved via reporting structures, regular meeting forums and analysis of data obtained from key performance indicators, clinical data, complaints, incidents, high impact/prevalence risks, human resource management and monitoring/auditing. I find requirement 8(3)(b) is compliant.

Requirement 8(3)(c)

Previously the service did not demonstrate effective organisation wide governance systems. Actions implemented since the assessment conducted 21-22 June 2023, include reviewing all open complaints and development of independent process to ensure feedback is acknowledged/actioned and responses received.

During this assessment contact information was gathered through interviews, observations, and document review. Effective organisation systems are evident relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Systems ensure stakeholders have information they need. Staff communication systems include access to organisational policy/procedure, electronic documentation systems, meeting forums. Most interviewed staff advise accessibility to information they need to deliver appropriate individual care/ role responsibilities. A program of regular meeting forums for consumers/representative ensures timely transfer of information and communication processes.

Continuous improvement opportunities/monitoring processes demonstrate organisational and specific service improvements. Pre-approved budgetary delegation ensures timely purchase of equipment/resources and a process available to gain authorisation for further spending as required. Workforce monitoring occurs at both service and organisation level via ongoing review of consumer care needs, clinical data, feedback from consumers and staff and legislative requirements. Duties/responsibilities are communication via position descriptions and regular monitoring/review of staff performance. Organisational teams identify/monitor compliance with regulatory requirements, update policy/procedures accordingly and provide staff education. Effective systems relating to comments/complaints is evident.

In consideration of compliance, I am swayed by evidence of effective organisation wide governance systems and volume of consumer satisfaction. I find requirement 8(3)(c) is compliant.

Requirement 8(3)(d)

Previously the service did not demonstrate risk management system and practices are used effectively to appropriately record (and manage) risks including incident management. Actions implemented since the assessment conducted 21-22 June 2023, include provision of education to clinical staff regarding identification/documentation of risks, including assessment and care planning updates.

During this assessment contact information was gathered through interviews, observations, and document review. Organisational risk management systems and practices are evident including a documented risk management framework and policies/procedures to guide management and staff in relation to high impact/prevalence risks, identifying/responding to abuse and neglect, and incident management. The strategic framework outlines key principles on supporting consumers to live their best life. The service demonstrate effective management of risks appropriately escalated via organisational reporting processes for Board member review/actioning. Guidance documents are informed by organisational internal specialists, (palliative care, pain, infection control, wound consultant) and flowcharts relating to Serious Incident Response Scheme, abuse and neglect guide organisational/legislative requirements. The incident management system is utilised to identify/mitigate risks and drive/inform continuous improvement. Staff receive training on incident reporting and legislative requirements.

In their response the approved provide supplied supporting effective organisational systems. In consideration of compliance, I am swayed by this evidence and volume of consumer satisfaction. I find requirement 8(3)(d) is compliant.

Requirement 8(3)(e)

Previously the service did not demonstrate an effective clinical governance framework, including antimicrobial stewardship, minimising restraint use and utilisation of open disclosure processes. Actions implemented since the assessment conducted 21-22 June 2023, include provision of intensive staff education on documentation requirements relating to restrictive practices, training relating to complex clinical care, staff requirement to complete education on principles of open disclosure. During this assessment contact information was gathered through interviews, observations, and document review. A comprehensive clinical governance framework relating to antimicrobial stewardship, minimising restrictive practice use and open disclosure practices is evident; topics are discussed at staff meeting forums and education provided to staff. Organisational policies/procedures guide staff in expectations. Monitoring processes ensure adherence to legislative requirements. Information related to open disclosure is embedded throughout organisational documents and included in the clinical governance framework. I find requirement 8(3)(e) is compliant.

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