Performance

Report

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| Name: | Para Hills Residential Care |
| Commission ID: | 6962 |
| Address: | 50 Kesters Road, PARA HILLS WEST, South Australia, 5096 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 22 November 2023 to 24 November 2023 |
| Performance report date: | 15 January 2024 |
| Service included in this assessment: | Provider: 1154 L P Rositano & M Rositano & R M Rositano and S P Rositano  Service: 4370 Para Hills Residential Care |

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 Para Hills Residential Care (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* the provider’s response to the assessment team’s report received 13 December 2023 which included plans for continuous improvement directly relating to the deficits identified by the assessment team, as well as documentation to support actions implemented; and
* the performance report dated 12 January 2023 for a site audit undertaken from 8 November 2022 to 10 November 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 | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **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 Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 2 requirements (3)(a) and (3)(e)**

* Ensure risks to consumers’ health and well-being are identified and appropriate management strategies developed and implemented to enable staff to provide quality care and services.
* Ensure care plans are reviewed for effectiveness and/or updated in line with the service’s processes, as well as in response to incidents and changes in consumers’ circumstances. Ensure care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure monitoring charts are regularly reviewed and evaluated to enable effective management strategies to be implemented to guide staff in provision of care.
* Ensure use of restrictive practices is in line with legislative requirements, including ensuring consultation is undertaken and appropriate consents and authorisations are obtained.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 requirements (3)(a) and (3)(b)**

* Ensure staff have the skills and knowledge to:
* provide clinical care to consumers in line with their assessed needs and preferences and that is tailored and optimises their health and well-being, specifically in relation fluid restrictions/output monitoring, and chemical restraint;
* identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks, including diabetes, and medications, such as time-sensitive medication administration and storage;
* Ensure policies, procedures and guidelines in relation to fluid restrictions/output monitoring, and chemical restraint, as well as management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to fluid restrictions/output monitoring, and chemical restraint, as well as management of high impact or high prevalence clinical risks.

**Standard 7 requirement (3)(c)**

* Ensure staff competency, skills and knowledge are assessed, monitored and tested to ensure staff are competent to undertake their roles.
* Review workforce monitoring processes to ensure deficits in workforce practices are identified and appropriate action implemented in a timely manner.

**Standard 8 requirement (3)(d)**

* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks, and managing and preventing incidents.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

**Requirements (3)(a) and (3)(d)** were found non-compliant following a site audit undertaken in November 2022 as each consumer was not treated with dignity and respect, with their identity, culture and diversity valued, nor were they safely supported to take risks to enable them to live the best life they can. The assessment team’s report provided evidence of actions taken to address the deficits identified, including, but not limited to, providing training to staff in dignity and respect and assisting consumers with meals; development of a dignity of risk learning module which has been completed by all staff; and review and update of the dignity of risk form.

At the assessment contact undertaken in November 2023, consumers were found to be treated with dignity and respect, with their identity, culture and diversity valued. Consumers and representatives said staff are kind, caring, respectful and understand consumers’ needs and staff were observed interacting respectfully with consumers. Staff were knowledgeable of individual consumer’s culture, diversity and identity and provided examples of care provision consistent with care files.

Consumers said they are supported to take risks to live the best life they can and confirmed staff have consulted with them regarding associated risks and mitigating strategies. Staff described how they support consumers to take risks, as well as mitigating strategies implemented consistent with consumers’ care files.

Based on the assessment team’s report, I find requirements (3)(a) and (3)(d) in Standard 1 Consumer dignity and choice 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. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as the two requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(a) and (3)(e) not met.

**Requirement (3)(a)** was found non-compliant following a site audit undertaken in November 2022 as assessment and planning, including consideration of risks to consumers’ health and well-being, did not inform delivery of safe and effective care and services. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, review of the admission process with two clinical staff required to confirm consumer allergies and update the electronic medication system upon admission; streamlined the admission process to ensure all assessments are completed in a timely manner; and conducted an audit of all medication charts and assessments to ensure congruency with consumer allergies and photographs.

However, at the assessment contact undertaken in November 2023, assessment and planning was found to not inform the delivery of safe and effective care and services, specifically in relation to chemical and environmental restraint and behaviour support plans. The assessment team’s report provided evidence indicating a care file for a consumer subject to chemical restraint did not evidence informed consent or consultation in relation to the risks, benefits and requirements for the medications, and the behaviour support plan did not include tailored strategies to support staff in managing changed behaviours. The representative confirmed the consumer is prescribed multiple medications to assist in management of behaviours, however, indicated they had not spoken to the prescribing medical officer relating to the risks, benefits and indications for the medications. The representative said they were told the medications are required to be prescribed. A restrictive practices authority form did not include information relating to the risks/benefits of using the medications, or alternative strategies trialled prior to use of medications. Additionally, the behaviour support plan did not include evidence of consultation and informed consent by the representative. For another consumer subject to environmental restraint, the behaviour support plan did not include identified behaviours, triggers, or mitigating strategies in relation to the environmental restraint to guide staff.

The provider’s response included planned actions to address the deficits identified, including review of behaviour support plans; and redesigning the risk assessment form to include medications, indications for use, side effects and a summary of consultation with representatives and/or consumers.

I acknowledge the provider’s response. However, I find assessment and planning processes have not been consistently undertaken to enable risks relating to restrictive practices to be identified and appropriate management strategies implemented. Behaviour support plans for two consumers did not include sufficient information relating to identified behaviours, including triggers and mitigating strategies. One of these consumers is identified in Standard 3 Personal care and clinical care requirement (3)(a) as displaying changed behaviours at any time throughout the day towards staff. Additionally, consultation with the representative of one consumer, including informed consent, had not been undertaken for use of chemical restraint and related documentation did not include information relating to the risks/benefits of using the chemical restraint, or alternative strategies trialled prior to use of the restraint. As such, I find the evidence presented demonstrates care plans are not tailored to consumers’ specific needs nor do they inform how, for each consumer, risks to their health and well-being have been considered to ensure care and services are safely delivered.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(e)** was found non-compliant following a site audit undertaken in November 2022 as care and services were not reviewed for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, providing training to clinical staff on ongoing assessment and planning; conducting weekly progress note reviews to ensure external referrals are followed up, incident reports are completed and appropriate information is captured in assessment and planning; and providing information to staff on pain management and directing them to commence pain charting if there are concerns or changes regarding pain.

However, at the assessment contact undertaken in November 2023, care and services were not being reviewed for effectiveness when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer. The assessment team’s report provided evidence indicating a care file for one consumer did not show monitoring of pain following a change in medications to ensure effectiveness. Clinical staff confirmed the consumer has chronic pain, and they monitor their pain and administer regular and as required medications. They said charting was commenced to monitor behaviour, however, did not indicate monitoring in response to medication changes.

A care file for one consumer demonstrated they can become physically aggressive towards staff. An incident evaluation and review of an incident which occurred in October 2023 did not include an investigation into the incident, including causes and contributing factors or review of the behaviour support plan. Behaviour charting is completed ongoing for the consumer, however, there is no evidence this had been reviewed or evaluated following the incident or potential causes investigated. There was also no evidence the charting is reviewed ongoing to ensure strategies are being utilised and they are effective. Clinical staff knew how to report incidents and their role in the initial identification of incidents, however, were not sure about what assessments should be completed and said they would refer to the policy and procedure.

The organisation’s policy and procedure states any consumer subject to chemical restraint must have the restraint reviewed every three months. While medications had been reviewed, there was no documented evidence for two consumers that representatives had been involved in the review.

The provider’s response included planned actions to address the deficits identified, including redesigning the risk assessment form to include medications, indications for use, side effects and a summary of consultation with representatives and/or consumers, with this information included in progress notes to track three monthly chemical restraint reviews. Education and toolbox training has also been provided to staff in relation to actions to take in response to medication changes.

I acknowledge the provider’s response. However, I find care and services were not regularly reviewed for effectiveness in response to changes in consumers’ care and service needs and incidents. I have considered following a change in a consumer’s pain management medication regime, appropriate monitoring processes were not undertaken to ensure effectiveness. For another consumer, ongoing behaviour charting has not been reviewed or evaluated to monitor effectiveness of current strategies, to guide development of new strategies to manage behaviours displayed, or to identify contributing factors following behaviour incidents. As such, I find this has not ensured care plans are current, that care and services are being delivered in line with consumers’ current needs and preferences or that risks to consumers and others are minimised.

For the reasons detailed above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to requirements (3)(a) and (3)(e)**, I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to these requirements.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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 is assessed as non-compliant as two of the three requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(a) and (3)(b) not met.

**Requirement (3)(a)** was found non-compliant following a site audit undertaken in November 2022 as each consumer was not receiving safe and effective care that was best practice, tailored to their needs, and optimised their health and well-being. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, reviewing all consumers subject to environmental restraint and completed risk assessments where required; updating the admission checklist to include a prompt for environmental restrictive practices; completion of a learning module on restrictive practice by all clinical staff; implementation of daily monitoring of consumers with indwelling catheters, with related documentation reviewed each shift and audited weekly.

However, at the assessment contact undertaken in November 2023, each consumer was not receiving safe and effective clinical care that was best practice, tailored to their individual and optimising their health and well-being, specifically in relation to behaviour support, administration of psychotropic medications, and monitoring of fluid input/output. The assessment team’s report provided evidence indicating for a consumer with an indwelling catheter, fluid output monitoring charting showed only 100mls of urine was documented over a 24-hour period. Progress notes did not show the consumer’s output had been reviewed for that day or that any investigation or actions to address the decreased output had been taken. A fluid output chart for a consumer on a fluid restriction included two dates in November 2023 where they had exceeded the restriction amount. Progress notes on these dates showed staff had reviewed the fluid balance chart and noted the increased amount, however, there were no additional actions noted in response to the fluid balance chart tally.

A care file for one consumer did not demonstrate as required psychotropic medications were used as a last resort after all alternative strategies had been utilised. As required medications to manage the consumer’s behaviours were administered five times over an eight day period in November 2023, however, progress notes did not clearly identify the indication and reason for administration in all cases, only stating anxiety. There was no evidence staff had assessed and treated the consumer for pain or constipation or encouraged them to watch specific programs as described by the representative.

The provider’s response included planned actions to address the deficits identified, including monitoring intake and output charts and undertaking audits to ensure correct procedures are followed and issues addressed. Staff have also been provided education on fluid intake and output recording, psychotropic medications, and consideration of contributing factors to a consumer’s behaviours.

I acknowledge the provider’s response. However, I find each consumer did not receive safe and effective clinical care, specifically in relation to fluid input/output and use of psychotropic medications. While fluid monitoring charts are maintained, the data collected is not being effectively monitored nor appropriate actions taken where issues are identified. This has resulted in no actions being taken in response to a consumer who exceed their daily fluid limit on two occasions and another consumer who had a reduced urine output over a 24-hour period. I have also considered for one consumer, the care file indicates psychotropic medications are not being used as a last resort, with indications for use not clearly identified, nor contributing factors for behaviours considered.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)** was found non-compliant following a site audit undertaken in November 2022 as high impact or high prevalence risks associated with the care of consumers were not effectively managed. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, auditing all medication charts and updating the weekly audit form to prompt clinical staff to review allergies, photograph date, administration instructions and assessments; and auditing of all diabetic management plans to ensure diabetic pathways are completed.

However, at the assessment contact undertaken in November 2023, effective management of high impact or high prevalent risks related to diabetes and medications was not demonstrated. The assessment team’s report provided evidence indicating one consumer’s blood glucose level (BGL) was recorded above the desired range on 17 occasions over a 21 day period in November 2023, with as required insulin not administered in line with medical directives on five of these occasions. Progress notes did not evidence as required insulin had been administered as directed, or that actions were taken to address the increased BGL. Another consumer’s BGL was documented to be below desired range on six occasions over a 21 day period in November 2023, however, there was no evidence this had been actioned on five of the six occasions.

Delays in administration of time-sensitive medications were noted for two consumers. While one consumer said staff are mostly compliant with providing them medications prior to the administration due time, they have experienced a couple of times where they have not received the medications on time. For another consumer, medication charting for a 22 day period in November 2023 showed medication was administered over 30 minutes early or late on 34 occasions, with the maximum delay noted as 3.5 hours. Additionally, for two consumers who self-administer medications, medications were not secured and were easily accessed by others.

The provider’s response included planned actions to address the deficits identified, including conducting audits on BGL monitoring, time-sensitive medications, and consumers who self-administer medications, including storage of medications; and providing education to staff on BGL documentation and time-sensitive medication.

I acknowledge the provider’s response. However, I find high impact or high prevalence risks relating to diabetes and medications were not effectively managed. For two consumers, staff did not take appropriate action in response to BGLs outside of reportable range, including administering as required insulin or rechecking BGLs in response to readings which were below the reportable range. Such practices do no ensure changes to consumers’ condition are effectively monitored and identified and prompt action taken in response. Time-sensitive medications have not been consistently administered on time which has the potential to impact consumers’ health and well-being, and medications for two consumers who self-manage this aspect of their care had not been securely stored.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**In relation to requirements (3)(a) and (3)(b)**, I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to these requirements.

**Requirement (3)(g)** was found non-compliant following a site audit undertaken in November 2022 as minimisation of infection related risks through application of standard and transmission-based precautions to prevent and control infection, and practices to promote appropriate antibiotic prescribing and use were not demonstrated. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, updating the acute respiratory infection outbreak management plan with recommended changes made by an external service; appointment of a second infection prevention and control lead; posting additional signage on entry to remind visitors to undertake a rapid antigen test prior to entry and processes for staff to check outcomes; and providing education on antimicrobial stewardship to clinical staff.

At the assessment contact undertaken in November 2023, minimisation of infection related risks using standard and transmission-based precautions and practices to promote appropriate antibiotic prescription were demonstrated. Consumers and representatives were satisfied with the service’s response to infection related risks and felt outbreaks were identified and responded to appropriately. Antimicrobial stewardship is practiced and action is taken to reduce the risk of infection related risks through current work practices, for example, specimens are collected and pathology confirmed prior to treating symptoms of infection. Staff were aware of infection control practices, including use of personal protective equipment, as well as strategies to minimise antibiotic use. They confirmed they receive ongoing training in infection control, donning and doffing of personal protective equipment and outbreak management.

Based on the assessment team’s report, I find requirement (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 5

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| Organisation’s service environment | |  |
| 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 |

Findings

**Requirement (3)(b)** was found non-compliant following a site audit undertaken in November 2022 as the service environment was not safe, clean and well-maintained. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, ongoing visits by pest control contractors resulting in decreased pest activity; installation of appropriate fire suppression equipment in the smoking area; employment of an external contractor to work in conjunction with the maintenance team; and repair of the external roof and installation of a new veranda

At the assessment contact undertaken in November 2023, consumers and representatives said the service is safe, clean, and well maintained and allows consumers to move freely both indoors and outdoors. The service is well maintained and clean throughout. Preventative and reactive maintenance processes, supported by contracted services are in place and weekly environmental audits are undertaken to identify any additional maintenance requirements. Staff described processes for alerting maintenance to any hazards or issues they identify and confirmed they attend to additional cleaning when requested.

Based on the assessment team’s report, I find requirement (3)(b) in Standard 5 Organisation’s service environment 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

**Requirements (3)(a), (3)(c) and (3)(d)** were found non-compliant following a site audit undertaken in November 2022 as consumers, representatives and others were not encouraged and supported to provide feedback and make complaints; appropriate action was not taken in response to complaints and feedback; and feedback and complaints were not reviewed and used to improve the quality of care and services. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, implementation of a QR Code system for stakeholders to provide feedback and make complaints direct to management; and conducted customer service education for all staff which included feedback and complaints handling processes.

At the assessment contact undertaken in November 2023, all consumers and representatives said they provide feedback regularly and felt encouraged to do so. Consumers are encouraged and supported to provide feedback and make complaints through various avenues, including surveys, meeting forums and provision of feedback forms. Feedback posters, forms and brochures were available in key locations, easily accessible to consumers. Clinical and care staff described how they support consumers and representatives to provide feedback, including through provision of feedback forms and assistance to complete these if required.

Consumers and representatives confirmed the service is prompt to make contact when things go wrong and apologises or expresses regret at these times. They feel complaints are handled well and addressed in a timely manner. Staff are guided in the complaints management process by policies and procedures which include open disclosure principles. Feedback data for a nine month period in 2023 demonstrated the use of open disclosure principles in the management of all complaints, with apologies provided to the consumer or representative, and actions taken to reach a mutual agreement and/or prevent reoccurrence.

Consumers and/or representatives said they have noticed changes to care and services based on feedback they have provided. Business processes guide staff in ensuring feedback provided is identified, captured, actioned, and reviewed to identify trends. Feedback and complaints documentation showed opportunities for improvement had been identified based on feedback data and were reflected on the service's plan for continuous improvement.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c) and (3)(d) in Standard 6 Feedback and complaints compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the two requirements assessed has been found non-compliant. The assessment team recommended requirements (3)(c) and (3)(e) not met.

**Requirement (3)(c)** was found non-compliant following a site audit undertaken in November 2022 as staff were not competent nor did they have the qualifications and knowledge to effectively perform their roles. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, providing training to staff on restrictive practices, antimicrobial stewardship, end of life and palliative care; providing toolbox education to clinical and care staff reiterating the importance of appropriate documentation of indwelling catheter output and ongoing monitoring; and development of a variety of clinical and care staff competencies.

However, at the assessment contact undertaken in November 2023, the assessment team were not satisfied the workforce was competent and had the knowledge to effectively perform

their roles. The assessment team’s report provided evidence indicating clinical staff did not implement appropriate monitoring of consumers’ pain following a change in pain management strategies; conduct reassessment of consumers’ behaviours post behaviour incidents or consider pain as a cause for the behaviours; monitor and take appropriate action in relation to BGLs outside of range and unusual fluid intake/output; provide time-sensitive medications when required; or ensure all medications are securely stored. Staff training records for 2023 included the provision of training relating to pain, diabetes management, medication administration, BGL competencies and minimising restrictive practice. While staff interviewed were aware of the subject matter this was not demonstrated in clinical practice. Two clinical staff interviewed said they had not received education in relation to time-sensitive medications and no evidence of this type of education was included in staff training records.

The provider’s response included planned actions to address the deficits identified, including providing staff training in relation to medication changes, behaviour management and documentation, BGL monitoring, fluid intake/output recording, and time-sensitive medications.

I acknowledge the provider’s response. However, I find the workforce was not sufficiently competent or had the knowledge to effectively perform their roles. In coming to my finding, I have considered the outcomes for consumers highlighted in Standard 2 Ongoing assessment and planning with consumers and 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to ensure effective assessment, planning and review or to support the delivery of safe and effective clinical care. Consumers have not been provided care that is tailored to their needs or optimised their health and well-being, or effective management of high impact or high prevalence risks. While training records showed staff had received training in relation to pain, diabetes, medication administration, and restrictive practices, and completed BGL competencies, deficits in the provision of care relating to these specific areas have been identified. I find this demonstrates the organisation’s systems to monitor whether staff skills are effective and that care is being delivered in line with the organisation’s policies, procedures and clinical governance framework have not been effectively applied. I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

**Requirement (3)(e)** was found non-compliant following a site audit undertaken in November 2022 as regular assessment, monitoring and review of the performance of each member of the workforce was not demonstrated. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, completion of outstanding staff appraisals; implementation of an appraisal template and internal auditing schedule to ensure monitoring of staff practice across all areas of care and service provision; and development of a performance monitoring, development and review policy.

However, at the assessment contact undertaken in November 2023, the assessment team were not satisfied assessment, monitoring and review of the performance of each member of the workforce was sufficient to identify poor clinical practice in relation to appropriate use of as required medications, administration of time-sensitive medications and BGL monitoring. The assessment team’s report provided evidence to indicate the service’s electronic medication management system has the ability to develop reports analysing data which can identify staff medication administration practices, including use of as required medications, times medications are administered and BGL monitoring. Management said they had not currently utilised these functions of the system to monitor staff performance but would consider implementing these forms of monitoring following consultation with various committees and staff to ascertain appropriate monitoring timeframes and processes.

The provider’s response included planned actions to address the deficits identified, including providing staff training in relation to BGL monitoring and time-sensitive medications.

Based on the assessment team’s report, I have come to a different view from the assessment team’s recommendation of not met and find the service compliant with this requirement. While I acknowledge deficits highlighted in the provision of consumers’ clinical care, specifically BGL monitoring and medication management, I consider this evidence is more related to the competence and knowledge of the workforce, as well as the service’s related monitoring processes, and have considered the evidence in my finding for requirement (3)(c) in this Standard. I also acknowledge the service has not used data available to them through their electronic management system to identify deficits in care, however, I find this more aligned to risk management systems and practices and have considered this evidence in my finding for requirement (3)(d) in Standard 8 Organisational governance.

In coming to my finding, I have considered evidence presented in the assessment team’s report demonstrating staff performance is reviewed following completion of probationary periods and annually thereafter. Staff are monitored daily by the clinical management team and registered nurse, and informal and formal conversations are conducted with staff identified as requiring further direction. Staff performance is monitored through data, such as feedback and complaints, and Serious Incident Response Scheme reporting. Clinical staff said they monitor care staff daily to ensure completion of daily tasks, provide guidance with care practices when required, and report any ongoing issues with performance to management.

For the reasons detailed above, I find requirement (3)(e) in Standard 7 Human resources 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. | Not 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

The Quality Standard is assessed as non-compliant as one of the five requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(d) not met.

**Requirement (3)(d)** was found non-compliant following a site audit undertaken in November 2022 as risk management systems and practices relating to managing high impact or high prevalence risks, managing and preventing incidents, and supporting consumers to live the best life they can were not effective. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, engagement of additional clinical governance committee members to increase clinical oversight; reviewed clinical indicator reports, the high risk register and meeting minutes to ensure they reflect best practice and legislative guidelines, including specific strategies, interventions and evaluations for individual consumers to manage their identified care needs; and reviewed the risk management framework to ensure high impact or high prevalence risks are closely monitored and regularly reviewed regularly.

At the assessment contact undertaken in November 2023, while the assessment team were satisfied effective systems and practices relating to high impact or high prevalence risks, identification and response to abuse and neglect, and supporting consumers to live the best life they can were demonstrated, they found systems and practices to manage and prevent incidents were not effectively applied. The assessment team’s report included evidence to indicate progress note entries for two consumers dated November 2023 included behaviour incidents which had not been reported through the incident management system. Management said due to large amounts of behavioural incidents for one of the consumers, care staff had started documenting these episodes in behaviour charts and progress notes rather than filling out incident reports. This practice was not in line with the organisation’s incident management policy. Evidence highlighted in Standard 2 Ongoing assessment and planning with consumers indicated an incident evaluation and review for an incident which occurred in October 2023 did not include an investigation, including cause or contributing factors. I have also considered evidence highlighted in requirement (3)(e) in Standard 7 Human resources indicating while the electronic medication management system can be used to track and analyse data which can identify staff medication administration practices, this function is not being utilised.

The provider’s response included planned actions to address the deficits identified, including educating staff in relation to incident form completion.

Based on the assessment team’s report and the provider’s response, I find the organisation’s risk management systems and practices relating to managing high impact or high prevalence risks and incident management have not been effectively applied. I acknowledge the electronic management system’s functions to enable staff practices to be analysed and tracked is not being used. However, I have considered the service’s monitoring processes overall have not been effective in identifying deficits in staff practices relating to management of high impact or high prevalence risks, including medication management practices and BGL which could potentially place consumers at risk. I have also considered consumer incidents are not being consistently reported or investigated, in line with the organisation’s processes. As such, incident data gathered may not be a true reflection of actual incidents occurring, or enable measures to safeguard consumers and prevent similar incidents from occurring to be implemented. I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirements (3)(a), (3)(b), (3)(c) and (3)(e)** were found non-compliant following a site audit undertaken in November 2022 as consumers were not engaged or supported in the development, delivery and evaluation of care and services; the organisation’s governing body did not promote a culture of safe, inclusive and quality care and services nor was accountable for that delivery; information management, continuous improvement and feedback and complaints governance systems were not effective; and the clinical governance framework was not effective in ensuring consumers received safe and quality care that met best practice and legislative guidelines. The assessment team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, reviewing feedback and complaints processes to increase opportunities for consumer and representative engagement; increasing promotion of consumer and representative forums; increasing consultation with consumers and representatives regarding current services; updating the management meeting agenda and minutes to include further information of clinical governance discussions and follow-up actions; providing ongoing staff education relating to various policies and procedures as they are developed or reviewed; and providing education to staff on antimicrobial stewardship and assessment and planning.

At the assessment contact undertaken in November 2023, consumers and representatives said they are engaged in the development, delivery and evaluation of care and service and feel supported by the service in this process. Management, clinical and care staff engage with consumers and representatives to gather feedback and suggestions across a range of care and service topics through informal chats, meeting forums, surveys and feedback processes. Partners regularly attend the service to meet and mix with consumers, representatives and staff to promote open and transparent relationships. A range of reporting mechanisms ensure the governing body is aware of and accountable for the delivery of care and services provided. The organisation’s values are promoted and communicated throughout the service, and the organisation has up to date policies, procedures and frameworks which describe the responsibilities and expectations of all individuals within the organisation. Consumers and representatives said the service is well run and management are very approachable. They expressed satisfaction with communication from management and the partners through face-to-face conversations, meeting forums and newsletters.

There are effective organisational wide governance systems, overseen by the partners and sub-committees, relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The organisation has a documented governance framework to describe key elements and an overview of governance systems, components, and tools. The framework defines the rules, relationships, systems, and processes by which authority is exercised and controlled within the organisation.

Clinical care is governed by an overarching clinical governance framework, including, but not limited to, antimicrobial stewardship, minimising the use of restraint and open disclosure. Clinical processes, staff training, policies and procedures guide clinical care. Staff were knowledgeable of practices to minimise restrictive practice and antimicrobial stewardship, and said policies and procedures are easy to access and follow. Incident documentation demonstrated the use of open disclosure principles when things go wrong.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(c) and (3)(e) in Standard 8 Organisational governance compliant.

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