Performance

Report

**1800 951 822**

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| Name of service: | Pathways Cronulla Pines |
| Service address: | 35 Sturt Road CRONULLA NSW 2230 |
| Commission ID: | 1029 |
| Approved provider: | Pathways Aged Care Pty Limited |
| Activity type: | Site Audit |
| Activity date: | 27 February 2023 to 2 March 2023 |
| Performance report date: | 28 April 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 Pathways Cronulla Pines (**the service**) has been prepared by   
M. Nassif delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* The assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The provider’s response to the assessment team’s report received 7 April 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

* Requirement 3(3)(b): Effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 5(3)(a): The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.
* Requirement 7(3)(d): The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

# Standard 1

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

Findings

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

Consumers said they were treated with dignity and respect. Staff were aware of the different cultural backgrounds of consumers and observed supporting and interacting with consumers in a respectful manner. Care planning documents recorded consumers’ culture, identity, and diversity.

Consumers were positive regarding the service’s recognition of their cultural values and backgrounds. Staff demonstrated awareness of consumers’ individual preferences and the provision of responsive care. Care planning documents included clear information about consumers’ cultural, spiritual and religious needs.

Consumers and representatives said consumers were supported to make decisions regarding care and services. Staff described supporting consumers to maintain relationships of importance and assist consumers to make decisions regarding their care. Care planning documents recorded choices made by consumers regarding care delivery.

Consumers said they were supported to take risks to do what was important to them and were observed being supported to take such risks. Staff knew of consumers who wished to undertake activities which presented potential risks and care planning documents evidenced risk assessments and informed consent.

The service was found non-compliant in Standard 1 in relation to Requirement 1(3)(e) following a site audit in May 2021. Evidence in the site audit report dated 27 February to   
2 March 2023 supports that the service has implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives said they received up to date information was observed to be displayed on noticeboards, through menus, hard copy weekly updates and newsletters. Management provided examples of improvements with communication methods of information sharing through consultation with both consumers and representatives. Meeting evidenced how the service had steadily improved communication of information to consumers. Information to assist consumers exercise choice, such as daily events and menus, were observed throughout the service.

Consumers said their privacy was respected and personal information kept confidential. Staff were observed knocking on consumers’ doors prior to entry and closing doors prior to care delivery. Privacy preferences were noted in care planning documents.

# Standard 2

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

Findings

The service was found non-compliant in Standard 2 in relation to Requirements 2(3)(c), 2(3)(d) and 2(3)(e) following a site audit in May 2021. Evidence in the site audit report dated   
27 February to 2 March 2023 supports that the service has implemented improvements to address the non-compliance and is now compliant with these requirements.

The Assessment Team recommended Requirement 2(3)(e) remained not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and have come to a different conclusion. My findings are:

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

* Not all care planning documents were reviewed every 4 months in line with organisational policy. This was addressed during the site audit with all care planning documents review being completed by the end of the site audit.
* Two consumer examples where appropriate reviews, for example for skin and toileting, were not conducted post fall incidents.

The provider’s response provided further evidence to demonstrate all care planning documents were now reviewed regularly in line with the organisational policy. The response acknowledged some care plans were not updated post incident and that the clinical team explained incidents are reviewed within 24 hours but there have been delays in documenting the review. The response outlined strategies to address this though it is noted that the Plan for Continuous Improvement (PCI) provided with the response did not address improvements in relation to Requirement 2(3)(e). The response provided evidence that, in relation to the 2 consumer examples who were not reviewed post incident, the consumers were reviewed by a physiotherapists and no changes was required to their care planning document in relation to the falls care plan. However, the response does not address if other aspects of the consumer’s care was reviewed to determine effectiveness of managing falls risk. This has been considered under Requirement 3(3)(b) where it is more relevant as it relates to the management of high impacts or high prevalence risks.

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

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

Staff described the care planning process in detail, and how it informs the delivery of care and services. Care planning documents evidenced assessments to identify, discuss and determine consumers’ needs, goals, preferences and risks, and included risk mitigation strategies. The service had assessment and care planning policies and procedures in place to guide staff.

Consumers and representatives said staff frequently engage them in discussions regarding care needs, including end of life needs, if desired. Staff described consumers’ needs, goals and preferences which were reflected in care planning documents.

Consumers and representatives said they were involved in care planning, assessment and review. Staff confirmed collaboration with various allied health professionals, such as speech pathologists and dieticians. Care planning documents evidenced assessment and planning undertaken in partnership with consumers, representatives, and allied health professionals.

Consumers and representatives said they were informed of care and service assessment outcomes in a timely manner. Staff said they discussed care planning documents with consumers and representatives over the phone, during video conferences and emailed copies to representatives. Staff confirmed care plans were easily accessible on the electronic care management system and care planning documents evidenced communication between consumers and those involved in their care.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found non-compliant in Standard 3 in relation to Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(f) and 3(3)(g) following a site audit in May 2021. Evidence in the site audit report dated 27 February to 2 March 2023 supports that the service had implemented improvements to address the non-compliances and is now compliant with Requirements 3(3)(a), 3(3)(d), 3(3)(f) and 3(3)(g). However, these improvements have not been effective in relation to Requirement 3(3)(b), and I find the service non-compliant with this Requirement and have provided evidence and reasoning below.

The Assessment Team recommended Requirement 3(3)(b) remained not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and my findings are:

Regarding Requirement 3(3)(b), the Site Audit report brought forward the following deficiencies:

* Consumer A, who is at risk of falls, was not monitored every 30 minutes according to documentation and as required in their care planning document. Clinical assessment was also not conducted after consumer A had a fall to ensure falls management strategies are assessed for effectiveness, including assessment of consumer A’s toileting needs to determine if this contributed to their falls. One strategy to manage consumer A’s risk of falls is a bed sensor however staff said the bed sensor was not working on the day consumer A had a fall.
* Consumer B is on fluid restrictions however their fluid intake was not consistently recorded to demonstrate monitoring of intake and for intake that was recorded, there was insufficient fluid in line with requirements in care planning documents. Consumer B also had a falls incident resulted in a wound and no clinical assessments were conducted post fall to better manage consumer B’s risks of falls or address the wound.
* Monthly clinical indicators demonstrated a notable increase in the number of falls in January 2023, found to result from insufficient monitoring and prevention strategies.
* Consumer C was not always provided pain relief in line with their care planning document prior to a catheter change. This caused the consumer pain and distress. The service was unable to provide evidence of staff undertaking training or competencies in catheter management.
* Consumer D was not provided 3 person assistance with transfer on one occasion as required by their care planning document.
* Management acknowledged most of the deficiencies and stated that reminders and training would be provided to staff.

The provider’s response provided the following evidence in response to some of the deficiencies brought forward in the Site Audit report:

* In relation to consumer A requiring monitoring every 30 minutes, the response acknowledged this did not occur and staff have since received additional training. Evidence was provided demonstrating 30 minutes monitoring occurred for one day post the site audit. In relation to clinical assessments not being conducted post fall, the response stated consumer A was assessed by the physiotherapist post fall and was determined that no changes to risk management strategies was required. The response provided evidence that other clinical assessments for consumer A have been completed and there were no changes. However, the response did not address if consumer A’s toileting needs were assessed to determine if this contributed to their falls. The response stated consumer A’s bed sensor has been replaced and upgraded to provide more effective falls monitoring. The response did not address or provide evidence that these improvements have resulted in reduced falls incidents for consumer A.
* The response acknowledged that consumer B’s fluid intake was not consistently recorded though staff are aware of monitoring requirements. Education on fluid documentation have been provided to staff. In relation to clinical assessments not being conducted post fall, the response stated consumer B was assessed by the physiotherapist post falls and was determined that no changes to risk management strategies was required. The response stated that although consumer B’s wound has healed post fall, it acknowledged that documentation of the wound was not timely.
* The response highlighted the service was experiencing a COVID-19 outbreak during this month and that preventing spread of the outbreak was the service’s priority. There was also a decrease in falls trend in the months prior to this.
* In relation to consumer C, the response acknowledged gaps in documentation in relation to pain relief administration but did not address if pain relief was provided in all instances. The response further stated additional training will be provided to staff in relation to catheter management.
* In relation to consumer D, the response stated investigations was undertaken and an apology offered to Consumer D who said they did not want to make a complaint. Additional training was provided to staff. As there was only one example brought forward of manual handling assistance not provided in line with a consumer’s transfer needs, I do not consider this alone sufficient to demonstrate systemic issues that risks in relation to mobility and transfers are not managed.

While I acknowledge the service has taken appropriate actions to address most of the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. Further, the response does not address all the deficits identified in the Site Audit report. Therefore, on the balance of evidence before me, I find Requirement 3(3)(b) non-compliant.

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

Consumers said they are happy with their personal care and clinical care. Care planning documents demonstrated consumers received safe and effective personal and clinical care that was tailored to consumer needs. Restrictive practices were best practice with authorisations by a medical officers and consumer/representative consent in place and non-pharmacological strategies trialled prior to restrictive practices. The service had policies and procedures available to staff for restrictive practice, pain and wound management.

Staff described care provided to consumers nearing the end of their lives and consumers palliating at the time of the site audit were observed being provided care which aligned with their care planning documents. Consumers said they are confident when they required end of life care, the service will support them to be as free as possible from pain and to have those important to them with them.

Consumers and representatives said the service recognised and responded to changes in condition in a timely manner. Care planning documents reflected identification of, and response to consumer deterioration. Staff confirmed they are guided by policies and procedures that supported them to recognise and respond to deterioration or changes in a consumer’s condition.

Consumers and representatives provided positive comments regarding staff communication of consumer information. Staff described sharing consumer information during shift handover and meetings, through care planning documents and the electronic care management system. Care planning documents included adequate information to support effective and appropriate sharing of consumers’ information to those involved in their care.

Consumers and representatives said referrals to other care providers were timely and appropriate. Staff confirmed the service had access to a network of allied health professionals and were knowledgeable of referral pathways. Care planning documents reflected timely and appropriate referrals to specialists, such as dieticians, dementia carers and medical officers.

Staff confirmed participating in infection control training and described infection prevention practices and appropriate antibiotic use. Staff confirmed monitoring medication usage and routinely reporting data to a medication advisory committee. Consumers and representatives said they were happy with the service’s management of COVID-19 precautions and other infection control practices.

# Standard 4

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

Findings

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

Consumers said they were supported to participate in activities of their choosing which encouraged independence. Care planning documents recorded consumers’ leisure preferences and interests, and staff described tailoring activities to align with consumer needs, including adjustments for consumers with reduced mobility.

Consumers said they were provided emotional and psychological support when needed. This was reflected in care planning documents. Staff provided examples of how they provide consumers with one-to-one conversations when they are feeling particularly low and advised what religious services visit the service.

Consumers said they were supported to undertake activities within the service and community, and to maintain personal relationships. Staff provided examples of activities including scenic bus rides, reading groups and exercise classes offered both inside and outside of the service. Care planning documents recorded people and activities of importance to consumers.

Consumers said information regarding their condition, needs and preferences was effectively communicated between the service and other providers. This information was appropriately recorded within care planning documents. Staff described exchanging relevant information with representatives or with staff during shift handover.

Consumers said they felt comfortable requesting referral to other organisations or care providers. External organisations were observed visiting consumers and staff described referring consumers to religious and emotional support services.

Consumers provided positive feedback regarding the variety, quality and quantity of meals. Staff said seasonal menus were developed or adjusted in response to consumer feedback received during meetings or through feedback forms. Care planning documents reflected dietary preferences and allergies which were shared with catering staff.

Consumers provided positive comments regarding the cleanliness of the service and equipment. All mobility and leisure equipment was observed to be clean and in good condition and a preventative maintenance schedule also evidenced audits to ensure equipment was clean and maintained.

# Standard 5

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

Findings

The service was found non-compliant in Standard 5 in relation to Requirements 5(3)(a), 5(3)(b) and 5(3)(c) following a Site Audit on 20 May 2021. Evidence in the site audit report dated 27 February to 2 March 2023 supports that the service had implemented improvements to address the non-compliance and is now compliant with Requirements 5(3)(b) and 5(3)(c). However, these improvements have not been effective in relation to Requirement 5(3)(a) and I find the Service non-compliant with this Requirement and have provided evidence and reasoning below.

The Assessment Team recommended Requirements 5(3)(a) and 5(3)(b) remained not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and have come to a different conclusion in relation to Requirement 5(3)(b). My findings are:

Regarding Requirement 5(3)(a), the Site Audit report provided there was no signage to shared amenities to assist consumers with navigation. With the exception of the memory support unit, consumer rooms are only identifiable by numbers. Consumers and staff continued to report the service environment was difficult to navigate and this was consistent with observations. Management acknowledged the deficiencies and advised temporary signage would be placed on bedroom doors and in shared areas and seek funding to purchase permanent signage.

The provider’s response stated a consumer meeting was held to get input from consumers on navigation signage. The response provided an interior designer is currently considering consumer recommendations and designs.

While I acknowledge the service has taken appropriate action to address the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes to demonstrate that the service is easy to understand for consumers to enable them to independently navigate around the service. Therefore, on the balance of evidence before me, I find Requirement 5(3)(a) non-compliant.

Regarding Requirement 5(3)(b), the Site Audit report brought forward the following deficiencies:

* Several consumer bedrooms which were stated as being ready for new consumers were observed to be unclean.
* Soiled and damaged carpet in common areas and unclean food pantries was observed.
* Consumers, representatives and staff expressed dissatisfaction with the cleaning in some areas of the service.
* Cleaning staff advised they do not follow the cleaning schedule as it sets out more tasks than they have time to complete.

The provider’s response outlined actions take to rectify each of the specific deficiencies identified in the Site Audit report as well as additional improvement actions to further address cleanliness of the service. I have also considered that only 2 consumer examples were brought forward in relation to complaints around cleanliness which the consumers said have been addressed and no impacts to consumers was identified. Therefore, on the balance of the evidence before me, I find Requirement 5(3)(b) compliant.

I am satisfied the remaining 1 Requirement in Standard 5 is compliant.

Consumers said equipment was readily available and were confident maintenance would be attended to promptly. Staff confirmed sufficient supply of equipment which was regularly cleaned. Documents evidenced up to date preventive and reactive equipment maintenance.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

This Standard is compliant as 4 of the 4 Requirements have been assessed as compliant.

Consumers and representatives said they felt comfortable to provide feedback or make complaints and understood the processes. Staff demonstrated how they supported consumers to make complaints. Management described various methodologies available to raise a concern or make a complaint such as through paper-based feedback forms, emails, telephone or online.

Consumers said they were aware of advocacy services and external complaint methods. Staff described assisting consumers to raise their concerns, including those with cognitive impairment and communication barriers, and were aware of language services available to consumers. Information regarding advocacy and language services was observed on posters, brochures and the consumer handbook.

Consumers and representatives said appropriate action was taken in response to their complaints and open disclosure was practiced. Management described how complaints were managed and resolved in a timely manner. Staff provided examples of where they have used an open disclosure approach by apologising to consumers when things go wrong.

The service was found non-compliant in Standard 6 in relation to Requirement 6(3)(d) following a Site Audit in May 2021. Evidence in this site audit report dated 27 February to   
2 March 2023 supports that the service has implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives provided positive comments regarding improvements made in response to their feedback. Management referenced a number of initiatives that had been implemented following feedback received that improved the services for consumers. A complaints register evidenced recording of feedback and complaints from various sources.

# Standard 7

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

Findings

The Assessment Team recommended Requirement 7(3)(d) not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and my findings are:

Regarding Requirement 7(3)(d), the Site Audit report brought forward the following deficiencies:

* Some consumers and representatives reported not feeling confident in the competency levels of staff regarding specialised areas of care.
* There was no training records to demonstrate staff had undertaken training in specialised areas of care such as catheter care, fluid restriction or diabetic management.
* The service was not able to demonstrate clear oversight and monitoring of staff training, including of agency staff.

The provider’s response acknowledged the deficits identified and stated staff will undergo training for catheter care, fluid restriction and diabetes management as part of the service’s plan for continuous improvement. The response also outlined changes to improve oversight and monitoring of staff training. The PCI provided with the response further outlined additional training to be provided to staff in relation to falls, fluid and catheter management and manual handling, which reflect deficits identified under Requirement 3(3)(b).

While I acknowledge the service has taken appropriate action to address the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(d) non-compliant.

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

Consumers and representatives said there were sufficient staff to provide care consumers required. Staff feedback reflected sufficient staffing to meet consumer care needs and staffing levels changed based on those needs. Documentation demonstrated the service used agency staff where required and no unfilled shifts.

Consumers and rep were kind, respectful and they felt valued by the service. Staff were observed interacting with consumers and each other in a respectful manner demonstrating the organisational values of harmony, respect, and trust.

Personnel records evidenced staff were recruited based on their qualifications, skills and experience. Consumers and representatives stated they felt staff were qualified prior to starting in their roles.

Staff said they received feedback from management regarding their performance through formal and informal channels. The service had a schedule of annual formal performance appraisals and management confirmed also providing feedback to staff following incidents, observations or complaints.

# 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

The Assessment Team recommended Requirement 8(3)(c) not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and my findings are:

Regarding Requirement 8(3)(c), the Site Audit report brought forward several deficiencies. I consider the following relevant to this Requirement:

* In relation to information management, the service utilised both electronic and hard copy information management systems and there was no clear guidance on where information should be recorded.
* In relation to continuous improvement, items on the service’s plan for continuous improvement remained not actioned, unresolved for extended periods, or were closed off without issues being addressed.
* In relation to workforce governance, the rostering system did not have a mechanisms to recognise new agency staff which prevented the service from being able to conduct inductions and competencies for new agency staff.

The provider’s response provided the following clarifying information in relation to the deficits identified above:

* Staff are able to use paper documents until a complete transfer to electronic documents has occurred.
* Additional processes have been implemented to increase PCI oversight processes and all outstanding actions have been completed.
* The service aims to employ regular agency staff who are inducted and provided with additional training.

In relation to deficiencies brought forward that related to information management, continuous improvement, and workforce governance, the evidence provided in the Site Audit report does not show absence of effective organisational wide governance systems in place. Further, no impacts on consumers was identified as a result of the deficiencies identified in the Site Audit report. I consider the evidence presented under this Requirement is insufficient to support non-complaint. Therefore, on the balance of evidence before me, I find Requirement 8(3)(c) compliant.

I am satisfied the remaining 4 requirements in Standard 8 are compliant.

Consumers and representatives said they were engaged in the development and delivery of care and services during care planning and consumer meetings. Meeting minutes evidenced the service was receptive to consumer feedback by implementing responsive changes.

Management demonstrated high level understanding of daily operations across the service and had engaged an external consultant to address deficiencies brought forward in the 2021 site audit. The organisation maintains a policy outlining the roles and responsibilities of each member of the governing body.

The service had effective risk management systems and practices, including managing high-impact or high-prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can and managing and preventing incidents.

The service had a clinical governance framework in relation to antimicrobial stewardship, minimising the use of restraints, and the principles of open disclosure. Staff were knowledgeable in these areas and had completed relevant training.

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