Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Prague House |
| Service address: | 253 Cotham Road KEW VIC 3101 |
| Commission ID: | 3100 |
| Approved provider: | St Vincent's Hospital (Melbourne) Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 25 May 2023 |
| Performance report date: | 28 June 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 Prague House (**the service**) has been prepared by S Byers, 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 16 June 2023 and 22 June 2023

# Assessment summary

|  |  |
| --- | --- |
| Standard 7 Human resources | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* **Requirement 8(3)(c)** – the approved provider ensures that organisation wide governance systems for information management, continuous improvement and regulatory compliance are operating effectively, staff demonstrate understanding of their roles and responsibilities in relation to each governance system, the new electronic management system is implemented, staff are trained in the new system and restrictive practices requirements including documentation requirements, the plan for continuous improvement is current and readily accessible, and the approved provider continues to undertake the actions outlined in their response, particularly relating to restrictive practices, and evaluate and embed the improvements into their usual practice so effective governance improves outcomes for consumers.

# Standard 7

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

Findings

The service was found Non-compliant in Standard 7 in relation to Requirement 7(3)(e) following a site audit in November 2022 where it was unable to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce including the completion of performance appraisals.

At the May 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous site audit.

The service demonstrated it has implemented a systematic performance appraisal process to monitor and review staff performance supported by policies and procedures. Management demonstrated understanding how to assess, monitor and review staff performance. Staff confirmed participating in annual appraisals and described how they use the appraisal process to identify training and professional development needs.  In addition to a formal appraisal process, staff described how they participate in informal discussions with management to receive and provide feedback and discuss performance and development. Appraisal documentation demonstrated that most staff have completed their performance appraisals for the current year.

Based on the available evidence, I find Requirement 7(3)(e) is Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirement 8(3)(c) is Non-compliant:

The service was found Non-compliant in Standard 8 in relation to Requirement 8(3)(c) following a site audit in November 2022 where it was unable to demonstrate:

* effective governance systems relating to information management, continuous improvement and regulatory compliance.

At the May 2023 assessment contact the Assessment Team identified ongoing deficits in information management, continuous improvement and regulatory compliance governance systems. I note that during the November 2022 site audit and the May 2023 assessment contact, the service was unable to provide documents requested by the Assessment Team, or they were delayed in their provision.

The service did not demonstrate that informed consent is obtained for all consumers subject to restrictive practices in line with legislative requirements. Clinical staff were not aware of informed consent requirements, stating that informed consent is the responsibility of management. Management acknowledged the deficits in restrictive practices, and advised that informed consent has been obtained for some consumers and is documented in progress notes, however this is not in line with organisational policy. The service did not provide requested documents relating to informed consent for consumers subject to restrictive practices including progress notes as it was not readily available or accessible to staff.

The service did not provide an updated Plan for Continuous Improvement (PCI). The approved provider provided the Assessment Team with a PCI dated March 2023 that included areas of improvement yet to be actioned in relation to restrictive practices at the November 2022 site audit. Management confirmed they did not have a current PCI.

The approved provider submitted a written response with clarifying information and documentation including restrictive practices records, restrictive practices implementation plan and a PCI. I acknowledge the service is in the process of changing electronic information management systems, and the implementation of the new system has been delayed due to a COVID outbreak and other operational challenges at the service. However, I consider it reasonable to expect that the actions identified at the November 2022 site audit were further progressed and implemented to improve consumer outcomes.

I have reviewed all of the information provided. While I acknowledge the actions taken by the approved provider since the assessment contact, these actions have not been fully implemented, evaluated or embedded. I am not satisfied the approved provider has demonstrated effective organisation wide governance systems relating to information management, continuous improvement and regulatory compliance. I find Requirement 8(3)(c) is Non-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)