Performance

Report

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| Name of service: | R M McHale Hostel |
| Service address: | 18 Purdey Street TONGALA VIC 3621 |
| Commission ID: | 3314 |
| Approved provider: | Respect Group Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 23 May 2023 to 24 May 2023 |
| Performance report date: | 10 July 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 R M McHale Hostel (**the service**) has been prepared by D Utting, 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 13 June 2023

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **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 2(3)(a)**: the approved provider ensures assessment and planning, including consideration of risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services. Specifically, risk of falls is consistently assessed and strategies to minimise risks are documented.

**Requirement 2(3)(b)**: the approved provider ensures assessment and planning identifies and addresses the consumer’s current needs, goals, and preferences. Care planning documentation includes the most up to date information about the consumers care needs.

**Requirement 2(3)(e)**: the approved provider ensures care and services are reviewed regularly for effectiveness. Consumers’ care reviews are triggered when there is a change in circumstances or when incidents occur, particularly for consumers experiencing falls.

**Requirement 3(3)(a)**: the approved provider ensures consumers personal and clinical care is safe, tailored to individual assessed needs and optimises the consumers health and well-being. In particular consumers subject to a chemical restrictive practice are administered medication as a last resort.

**Requirement 3(3)(b)**: the approved provider ensures the effective management of high-impact or high-prevalence risks associated with the care of each consumer. Specifically in relation to falls management the service ensures that consumer risks are identified, assessed and mitigation strategies implemented.

**Requirement 3(3)(d)**: the approved provider ensures 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. Staff have knowledge of escalation processes when consumers’ clinical observations are outside the normal range.

**Requirement 6(3)(c)**: the approved provider ensures they are capturing complaints and feedback and staff know how to report consumer feedback and complaints. The approved provider is able to demonstrate they are taking appropriate action to complaints and using open disclosure processes when things go wrong.

**Requirement 6(3)(d)**: the approved provider ensures feedback and complaints are reviewed and used to improve the quality of care and services at the service.

**Requirement 8(3)(a)**: the approved provider ensures consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The approved provide consults with consumers about changes that maybe occurring.

**Requirement 8(3)(c)**: the approved provider ensures the effective use of organisation wide systems which help to improve outcomes for consumers. The service has in place a plan for continuous improvement (PCI) to ensure action is taken to address identified deficits in care and service delivery.

**Requirement 8(3)(d)**: the approved provider ensures the implementation of effective risk management systems to identity, report, prevent and manage risks and incidents. Staff are trained in how to use these systems and supported to consistently utilises these systems to ensure quality care for consumers.

**Requirement 8(3)(e)**: the approved provider the approved provider ensures their clinical governance framework is effective in minimising the use of restraint and open disclosure. Staff demonstrate understanding of relevant policies and procedures and complete training and education on restrictive practices and open disclosure to effectively apply policy in practice. The processes to support early detection and identification of risks associated with clinical care are effective.

# 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. | Non-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. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 2(3)(a), 2(3)(b) and 2(3)(e) are Non-compliant.

The service was found Non-compliant with Requirements 2(3)(a), 2(3)(b) and 2(3)(e) following a Site Audit conducted in August 2022. At the time of the Site Audit care planning documentation did not include strategies to mitigate the risk associated with restrictive practice, falls and responsive behaviours. Care planning documentation did not always include current information about consumers care and the service was not consistently reviewing consumers incidents.

At the May 2023 Assessment Contact the Assessment Team identified ongoing deficits in assessment and care planning. The service continues to demonstrate inconsistencies in the assessment of consumers care, effectively identifying consumers at risk and documenting strategies to mitigate this risk. Consumer incidents are not evaluated and do not trigger a care review.

In relation to requirement 2(3)(a), the service did not demonstrate assessment and planning, including consideration of risks to a consumer’s health and well-being informs the delivery of safe and effective care and services, particularly in relation to falls management. Staff interviewed were not able to demonstrate knowledge of the assessment and planning process and when to complete validated assessment tools. Care planning documentation for one consumer sampled was incomplete and did not identify or assess the consumers falls risk. This consumer consequently experienced a fall causing injury and at the time there was no evidence of a falls strategy in place to minimise the consumer’s risk.

In relation to requirement 2(3)(b), care planning documentation did not record consumer’s current assessed needs. For two consumers experiencing falls care planning documentation did not record falls prevention strategies or include updated assessed falls risk following falls incidents. Staff interviewed were not able to identify sampled consumers with falls risk or strategies in place to mitigate the risk associated with falls. Behaviour support plans for two consumers did not include individualised strategies. Staff interviewed were not able to describe any specific strategies to support these consumers with changed behaviours.

In relation to Requirement 2(3)(e), while consumers and representatives interviewed confirmed they are notified when an incident occurs, they said they were not involved in the assessment and care planning following the incident. Falls incident documentation reviewed by the Assessment Team demonstrated that following a fall, incidents were not investigated and strategies were not implemented to prevent further incidents. Staff demonstrated knowledge of post falls monitoring but were not able to describe the assessments and interventions considered post fall, or when a consumer returns from hospital.

The service submitted a plan for continuous improvement (PCI) in response to the May 2023 Assessment Team report. No other supporting evidence was submitted to refute the findings presented in the Assessment Team report.

The PCI details planned actions including review of care planning documentation for all consumers, review of use of validated tools, identification of risks for consumers, education sessions for staff in a range of topics relating to assessment and planning and oversight by the organisation’s transformation team and quality teams.

While the approved provider’s response includes details of how they plan to address the identified deficits in assessment and planning these improvements are yet to be fully implemented, evaluated, and embedded for effectiveness. I am not satisfied the service has in place effective assessment and planning systems to ensure risks to the consumers health and well-being are considered, current needs, goals and preferences are identified and addressed; and care and services reviewed for effectiveness when circumstances change or when incidents impact the needs or goals of consumers. I find Requirements 2(3)(a), 2(3)(b) and 2(3)(e) are Non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(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. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 3(3)(a), 3(3)(b) and 3(3)(d) are Non-compliant.

The service was found Non-compliant following a Site Audit conducted in August 2022. At the time of the Site Audit the Assessment Team found that the service did not;

* recognise the use of regular and as required (PRN) psychotropic medication as chemical restraint and psychotropic medications were not being used as a last resort.
* consumers who were subject to a chemical restrictive practice did not have a behaviour support plan (BSP) in place.
* behaviour management practices were always effective and strategies were not always implemented, monitored, or evaluated.
* falls incidents were not always responded to effectively and the organisation did not demonstrate it analysed incidents for trends to minimise future risks.

At the May 2023 Assessment Contact the Assessment Team identified ongoing deficits in personal and clinical care, management of risks and response to deterioration.

In relation to Requirement 3(3)(a) the service was unable to demonstrate each consumer gets safe and effective personal care, clinical care. The Assessment Team identified two consumers where chemical restraint is not being used as a last resort. For one consumer while pain is an identified trigger for changed behaviours there was no evidence that staff were completing pain assessments prior to administering the chemical restraint. Staff did not demonstrate knowledge in the use of chemical restrictive practices and did not demonstrate understanding of legislative requirements.

In relation to Requirement 3(3)(b), consumers and representatives interviewed were not aware of any strategies in place for falls management or any ongoing monitoring in relation to a consumer’s responsive behaviours. Care documentation demonstrated falls strategies were not implemented to prevent further incidents. For one consumer with changed behaviours, while there was behaviour charting completed, there was no evidence the charting was evaluated or monitored. For one consumer who had experienced several falls there was no documented post fall review by the physiotherapist and no documented care strategies to minimise falls. Staff did not demonstrate knowledge of falls strategies in place for individual consumers and clinical staff did not demonstrate understanding of the process in monitoring and evaluating behaviour charting for effectiveness.

In relation to Requirement 3(3)(d), consumers and representatives confirmed they are contacted when an incident occurs, however, care documentation demonstrated deterioration or changes in a consumer’s condition is not always identified and responded to in a timely manner. The Assessment Team found that incidents did not trigger a review of consumers care needs. The service had not responded in a timely way to one consumer with low blood pressure readings, fall incident and progress notes documenting dizziness and poor appetite. Staff interviewed said they were not aware of any changes to this consumers condition.

The service submitted a plan for continuous improvement (PCI) in response to the May 2023 Assessment Contact. No other supporting evidence was submitted to refute the findings presented in the Assessment Team report.

The PCI details planned actions including care manager oversite of all charting, staff education, physiotherapy review implemented following falls, updating alert systems in electronic care system and staff practice evaluation.

While the approved providers response includes details of how the approved provider will address the identified deficits in personal and clinical care delivery, these improvements are yet to be embedded and evaluated for effectiveness. I am not satisfied the service has in place effective systems to ensure each consumer gets care that is best practice, tailored to their needs or optimises their well-being, effective management of high impact and high prevalence risks including behaviour management and falls, and timely recognition and response to deterioration or changes in a consumer’s physical function or condition. I find Requirements 3(3)(a), 3(3)(b) and 3(3)(d) are Non-compliant.

# Standard 6

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

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 6(3)(c) and 6(3)(d) are Non-compliant:

The service was found Non-compliant with Requirements 6(3)(c) and 6(3)(d) following a Site Audit conducted in August 2022. At the time of the Site Audit the service did not have a complaints register and there were no actions on the continuous improvement plan as a result of feedback and complaints. The service was unable to demonstrate they were taking appropriate action when complaints and feedback had been provided by consumers and representatives. Staff could not demonstrate their understanding of open disclosure but were able to locate electronic organisational policies and procedures.

At the May 2023 Assessment Contact the Assessment Team found ongoing deficits in the actions taken to address feedback and complaints and the use of feedback and complaints to improve the quality of care and services. While the service has implemented actions in response to the non-compliance identified regarding open disclosure, appropriate action is not being taken in response to feedback and complaints. Consumers and representatives interviewed were dissatisfied with the way complaints are resolved and said they had not made formal complaints in the last 6 to 12 months because they are rarely actioned. The Assessment Team review of documentation showed there were some entries recorded in the complaints register and there was no link with the Plan for Continuous Improvement (PCI). At the time of the Assessment Contact the service was unable to show that the PCI had actions included that related to consumer feedback.

The service submitted a PCI in response to the May 2023 Assessment Contact. No other supporting evidence was submitted to refute the findings presented in the Assessment Team report.

The PCI details planned actions including an internal review of progress notes to capture complaints, staff education, adding feedback from consumer meetings to the plan for continuous improvement and communiques to staff and consumers to encourage feedback and complaints. These corrective actions are being overseen by the organisation’s transformation team and quality team.

While the approved providers response includes details of how they will address the identified deficits in the systems that capture consumers feedback and complaints to make improvements to the quality of care and services, these improvements are yet to be embedded and evaluated for effectiveness. For this reason, I find the service Non-complaint in Requirements 6(3)(c) and 6(3)(d).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirements 7(3)(d) and 7(3)(e) were found Non-compliant following a Site Audit conducted in August 2022. At the time the Assessment Team found that not all mandatory training, in particular serious incident response scheme (SIRS) and managing risk, had been completed and monitoring of completion was not in place. The Assessment Team also found that while the organisation had a performance appraisal process in place it had not been actioned and staff received limited feedback about their performance.

At the May 2023 Assessment Contact, the Assessment Team found that the service has implemented improvements to address the non-compliance. In relation to Requirement 7(3)d) consumers interviewed said they were satisfied that staff knew what they are doing. Staff interviewed confirmed they have attended training on topics such as serious incident response scheme (SIRS), restrictive practices, open disclosure, and antimicrobial stewardship. Training and education documentation reviewed by the Assessment Team showed a range of education sessions have been conducted for staff with 100% completion rate for registered nurses.

In relation to Requirement 7(3)(e) the service demonstrated that the staff appraisal system in place is now being utilised. Staff interviewed confirmed they complete a reflection survey annually and are able to request one-to-one meetings with management to discuss performance. Management also said that discussions with staff occur where there is an identified performance issue. The Assessment Team review of staff reflection surveys noted that all staff that had requested one-to-one meetings had been held.

Based on the available evidence, I find Requirement 7(3)(d) and 7(3)(e) are Compliant. Staff are regularly assessed and reviewed for performance and have the opportunity to discuss any skills training needs. While the service has demonstrated improvement in the implementation of systems and processes to ensure that the workforce is recruited, trained, and supported to deliver the outcomes of the quality standards, the non-compliance outlined in Standard 2 and Standard 3 indicate that staff may require further support to effectively apply the education and training they are receiving. I am satisfied the service will continue to embed and evaluate the processes and systems in place to ensure the workforce is skilled and trained to deliver quality care and services in accordance with the quality standards.

# 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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e) are Non-compliant.

The service was found Non-compliant with Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e) following a Site Audit conducted in August 2022. At the time of the Site Audit the Assessment Team found that the service did not;

* provide opportunities for consumers to be involved in the planning and development of care and services
* demonstrate effective use of the governance systems the organisation has in place for information management, continuous improvement, workforce governance, regulatory governance, and feedback and complaints.
* demonstrate effective use of risk systems
* ensure management and staff were clear of the principles of anti-microbial stewardship, the use of restraint and open disclosure.

At the May 2023 Assessment Contact the Assessment Team found ongoing deficits in Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e).

In relation to Requirement 8(3)(a), consumers and representatives interviewed were not satisfied they can participate in the decisions about how care and services are delivered. They said that while they speak up at consumer meetings, they do not believe their opinions and suggestions are considered. The Assessment Team found that the communication with consumers about refurbishments and the seeking of their input was inconsistent.

In relation to Requirement 8(3)(c), the service was not able to demonstrate that it has effective organisation wide governance systems. In relation to continuous improvement the Assessment Team was not provided with a Plan for Continuous Improvement (PCI) that clearly evidenced planned actions to address the previously identified non-compliance. In relation to feedback and complaints the service was not able to demonstrate that there is a system in place to capture complaints and feedback and use this information to inform improvements in delivery of care and services. Not all staff interviewed demonstrated a clear understanding of the policies and procedures that either authorise or inform their decisions in delivering support, care, and services to consumers.

In relation to Requirement 8(3)(d), the service did not demonstrate effective and consistent use of risk management systems. While staff are reporting incidents these are not analysed to inform improvements in care delivery for consumers. There was no evidence that falls incidents are evaluated and analysed. Staff could not describe their responsibilities in relation to identifying and reporting risks including completion of weight management, behaviour management, or wound management charting. At the time of the Assessment Contact management acknowledged gaps in relation to the application of the policies and procedures relating to risk management by staff.

In relation to Requirement 8(3)(e), I have considered the non-compliance outlined in Standards 2 and 3. While the Assessment Team identified the service has a clinical governance framework in place this is not effective in minimising the use of chemical restrictive practices. Consumers subject to a chemical restrictive practice are not being effectively managed to ensure that other strategies are utilised before administering psychotropic medication.

The service submitted a PCI in response to the May 2023 Assessment Contact. The service did not submit any additional information to refute the findings of the Assessment Team.

The PCI includes planned actions to appoint a representation of consumers to meet with management monthly, staff capability review, staff education and completion of an audit by transformation team to identify gaps.

While I acknowledge the planned actions have commenced, they have not been fully implemented and evaluated. I am not satisfied the service has in place effective governance systems, consistently utilises the risk management systems and clinical governance systems to ensure the delivery of safe and quality care and services. Consumers are currently not supported and engaged in the development, delivery and evaluation of care and services. I find Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e) are 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)