Performance

Report

**1800 951 822**

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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: | Site Audit |
| Activity date: | 16 August 2022 to 19 August 2022 |
| Performance report date: | 17 October 2022 |

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 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 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 21 September 2022

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-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 | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **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 is completed comprehensively and accurately and considers risks to the consumer’s health and well-being.
* Requirement 2(3)(b) – the approved provider ensures each consumers needs, goals and preferences are identified and addressed through a comprehensive assessment and planning process that records accurate and complete information.
* Requirement 2(3)(e) – the approved provider ensures effective processes are in place to review care and services when circumstances change or when incidents occur, particularly regarding falls and responsive behaviours.
* Requirement 3(3)(a) – the approved provider ensures each consumer gets safe and effective personal and clinical care including in the areas of restrictive practices and behaviour support.
* Requirement 3(3)(b) – the approved provider ensures effective management of high-impact or high prevenance risks, including the identification, monitoring, management and evaluation of risks for individual consumers who experience falls and responsive behaviours.
* Requirement 3(3)(d) – the approved provider ensures effective processes are in place for staff to recognise and respond to deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition in a timely manner.
* Requirement 6(3)(c) – the approved provider ensures appropriate action is taken in response to feedback and complaints, consumers and representatives are informed of actions taken and feedback, complaints and relevant actions are appropriately documented, and staff demonstrate understanding of open disclosure in practice.
* Requirement 6(3)(d) – the approved provider ensures feedback and complaints are used to improve the quality of care and services; consumers, representatives and staff are informed of how feedback and complaints are used to improve the quality of care and services and feedback and complaints are appropriately documented to ensure the review and monitoring of trends.
* Requirement 7(3)(d) – the approved provider ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes under the Quality standards, staff will complete mandatory training with completion monitored, staff will complete training on incident reporting and the services incident management system.
* Requirement 7(3)(e) - the approved provider ensures assessment, monitoring and review of the performance of each member of the workforce occurs through their annual performance reviews and on a regular basis.
* Requirement 8(3)(a) – the approved provider ensures consumers are supported to be engaged in the development, delivery and evaluation of care and services and consumers are aware of how they can be involved and how their involvement has contributed to outcomes and continuous improvement.
* Requirement 8(3)(c) – the approved provider ensures that organisation wide governance systems for information management, continuous improvement, regulatory compliance and feedback and complaints are operating effectively in the service and the approved provider continues to undertake the activities outlined in their response and embed improvements into their usual practices.
* Requirement 8(3)(d) – the approved provider ensures effective risk management systems and practices including ensuring the service identifies, assesses and manages the high-impact and high-prevalence risks associated with the care of consumers, staff education and training on high impact and high prevalence risks including incident reporting and incident management systems to ensure incidents are identified, managed, monitored and resolved.
* Requirement 8(3)(e) – 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.

# 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

Consumers and representatives were satisfied that staff and management treat them with respect and dignity, and their culture and diversity is valued. Staff were observed treating consumers with dignity and respect and demonstrated an understanding of individual consumers choices and preferences. Care planning documents contained information about consumers’ past and current interests and preferences.

Consumers and representatives were satisfied the service provides care and services that are culturally safe. Staff provided examples of how they support consumers’ cultural needs when delivering care and services. Care planning documents aligned with information provided by consumers.

Consumers and representatives were satisfied they can make and communicate decisions about care and services, make connections and maintain relationships of choice. Consumers provided examples of how staff support them to maintain relationships with family and friends.

Consumers and representatives were satisfied the service supported consumers to do the things they wanted to do, including where the activities involve risk, so they could live the best life they can. Staff demonstrated understanding of risk based activities that consumers wished to participate in. Care documentation reflected risk assessments and discussions with consumers around risk strategies to mitigate the risk.

Consumers and representatives confirmed receiving current, accurate and timely information to enable choice. Consumers and representatives provided examples of information they have received including a monthly lifestyle program, lifestyle activity reminders and daily menus. The daily menus were observed on display throughout the service. In response to consumers and representatives’ feedback about not receiving newsletters, management committed to recommencing monthly newsletters later this year.

Consumers and representatives were satisfied their privacy is respected. Staff provided examples of how they respect consumer privacy and maintain the confidentiality of personal information. Observation of staff practice demonstrated the privacy of consumers is respected.

# 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)(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. | 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:

Assessment and care planning documentation did not demonstrate consideration of risk to the consumer’s health and well-being in a timely manner and did not use validated risk assessment tools. Care planning documents did not include strategies to mitigate the risk associated with restrictive practices, falls and responsive behaviours.

Assessment and care planning documentation did not identify and address the consumer’s current needs, goals and preferences. Care planning documents for consumers with responsive behaviours and falls risks did not reflect accurate information to inform staff of the consumers’ current needs. While consumers and representatives are consulted about advance care planning, this information is not reflected in the consumers’ end of life care plans.

The Assessment Team found that review of care and services were not always occurring when circumstances change or when incidents impact on the goals and preferences of the consumers. Document review demonstrated inconsistencies in the recording of incidents and completion of incident reports and investigations. Consumers were not always reassessed or reviewed after incidents relating to responsive behaviours and falls to develop strategies to prevent similar incidents occurring in the future.

The approved provider responded to the site audit report and accepted the Assessment Team’s findings. The approved provider submitted a detailed action plan demonstrating the actions planned to address the improvements required. Actions include reviewing and updating assessment and planning documentation, care consultations with consumers and representatives, implementation of processes to reinforce clinical oversight and regular monitoring of incident management, and staff training and education in incident management, behaviour and pain assessment and charting after falls.

The approved provider advised it took ownership of the service in March 2022 and is transitioning the service from a paper based system to an electronic system. Due to the significant change in documentation systems, the assessment and care planning for all consumers is ongoing as the approved provider is working towards embedding practices at the service. Training in the new systems is ongoing for staff.

I have reviewed all of the information provided and note the approved provider’s acknowledgement of the information compiled in the site audit report. While I acknowledge the actions taken by the service since the site audit, these actions have not been fully implemented and evaluated. 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.

I am satisfied the remaining two requirements of Standard 2 Ongoing assessment and planning with consumers are compliant:

Most consumers and representatives described their participation and others they wish to involve in the assessment, planning and review of their care. Staff and management discussed how the consumers, representatives, other health professionals and external health services collaborate to ensure the delivery of safe and individualised care. Care documents demonstrated communication with representatives and input from other health professionals including physiotherapists and dietitians.

Most consumers and representatives were satisfied the outcomes of the consumers assessment and planning are communicated effectively including when incidents occur. Care documents demonstrated communication of outcomes with consumers and representatives. While copies of care plans are currently not being provided to consumers due to the transition between document systems, this has been communicated to consumers and representatives. Staff described how they access the consumers’ progress notes and care plans, demonstrating they are readily available.

# 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)(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. | Non-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

I have assessed this Quality standard as non-compliant as I am satisfied requirement 3(3)(a), 3(3)(b) and 3(3)(d) are non-compliant:

While consumers and representatives expressed satisfaction that consumers’ care needs, and preferences are being met, the service did not demonstrate that each consumer receives clinical care that is effective, safe, and optimises their health and well-being. The service did not recognise the regular and ‘as required’ psychotropic medication prescribed to two consumers was chemical restraint. The Assessment Team presented evidence that psychotropic medication was not used as last resort for a consumer where the medication was prescribed to manage behaviour. Neither consumers had a behaviour support plan in place. Staff and management did not demonstrate understanding of chemical restraint, advising the Assessment Team that no consumers at the service were subject to any form of restrictive practices.

The Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The Assessment Team’s evidence included falls and behaviour management. Behaviour management practices were not always effective and strategies were not always implemented, monitored or evaluated. When incidents were investigated, the documented actions did not demonstrate a comprehensive or best practice approach to managing and responding to responsive behaviours and falls and the service did not demonstrate it analysed incidents for trends to minimise future risks. While a consumer assessed as a high falls risk who experienced several falls was reviewed by the physiotherapist, recommended strategies were not reflected in the consumer’s care plan. For two consumers with escalating behaviours, behaviour charting was not initiated to monitor and review behaviour and interventions to determine effectiveness. While staff were aware of some of the high prevalence or high impact risks for consumers, they did not demonstrate understanding or awareness of effective strategies to minimise the risks.

While consumers and representatives said they are contacted after incidents happen, care documents did not reflect the timely identification of, and response to changes in the health status of consumers. The Assessment Team presented evidence of one consumer who experienced a fall resulting in deteriorated functional capacity and injury, and two consumers who experienced ongoing escalating responsive behaviours. Documentation review identified it almost 2 months after the consumer’s fall before the service recognised and responded to the consumers respiratory issues and fractured ribs. Pain charting, pain assessment and pain management was not commenced despite the consumer’s ongoing complaints of pain. Assessment and care planning documents were not reviewed and updated following incidents to identify changes in care needs. Staff did not demonstrate sufficient understanding of how to recognise and respond to deterioration.

The approved provider responded to the site audit report and accepted the Assessment Team’s findings. The approved provider submitted a detailed action plan demonstrating the actions planned to address the improvements required. Actions included reviewing and updating consumer documentation to reflect current personal and clinical needs, reviewing consumers prescribed psychotropic medications in consultation with medical practitioners, implementation of processes to reinforce clinical oversight and regular monitoring of incident management, and staff training and education including restrictive practices, high impact and high prevalence risks, recognising and responding to deterioration.

I have reviewed all of the information provided and note the approved provider’s acknowledgement of the information compiled in the site audit report. While I acknowledge the actions taken by the service since the site audit, these actions have not been fully implemented and evaluated. 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.

I am satisfied the remaining four requirements of Standard 3 Personal and clinical care are compliant:

Consumers and representatives were satisfied the needs, goals and preferences of consumers nearing end of life are recognised and addressed. Care documents reflected consultation with representatives, staff and multidisciplinary teams to ensure comfort is maximised and end of life wishes respected.

While the Assessment Team identified deficits in the accuracy of consumers assessments and care plans, the service demonstrated that it has processes in place to ensure information about changes in a consumer’s condition, needs and preferences are reflected in consumer progress notes and communicated through verbal handover. Staff demonstrated knowledge about individual consumer’s care needs and preferences and described how they refer to progress notes and verbal handover to keep informed.

All consumers and representatives were satisfied they have access and referral to their medical practitioner, allied health professionals, and other external specialist services. Referral processes are in place and appropriate and timely referrals documented.

Consumers and representatives provided positive feedback on the service’s management of recent COVID-19 outbreaks and staff hand hygiene practices. Staff described how they minimise the use of antibiotics in the service. The service has appointed an Infection Prevention Control Lead (IPC) who is enrolled in the relevant IPC lead training. The service has an Outbreak Management Plan and relevant antimicrobial stewardship policies and procedures in place to guide staff practice. The service was observed to undertake appropriate entry screening in line with transmission based precautions and staff adhered to infection control practices, including the use of Personal Protective Equipment (PPE).

# 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

Most consumers and representatives interviewed were satisfied that the consumers get safe and effective services and supports for daily living which meets their needs, goals and preferences. Care planning documents identified consumers’ needs and reflected the services and supports to assist consumers to do the things they want to do. Staff and care documents provided examples of how the service supports consumers to access appropriate care and services to optimise independence. Staff described individual consumers’ needs and preferences. The Assessment Team identified deficits with the service’s current lifestyle program. The lifestyle program was observed to be limited, planned without consumer consultation and did not engage all consumers. The approved provider submitted evidence to demonstrate the lifestyle program is being reviewed in consultation with consumers, representatives and lifestyle staff to ensure it is tailored to meet all consumer’s needs and preferences. I have considered the positive feedback from consumers and representatives and the approved provider’s response. On balance, I am satisfied Requirement 4(3)(a) is compliant.

Consumers and representatives were satisfied consumers’ emotional, spiritual, and psychological well-being is supported. Staff provided examples of how they support consumers when they are feeling low including one on one time, this aligned with care documents.

Consumers and representatives were satisfied the services and supports provided by the service enable them to participate in the community, have relationships and do the things of interest to them. Staff described how they support consumers to do the things that are important to them, participate within and outside the service environment and have social relationships. For example, with COVID-19 restrictions limiting consumers access to the community, the service arranged a pen pal program with a local school. Care planning documents reflected individual consumers’ interests and identified the people important to them.

The service has processes in place to document and share information about the consumer’s condition, needs and preferences and demonstrated information is communicated effectively within the service. This was supported by staff and others involved in the consumer’s care demonstrating knowledge and awareness of the consumers’ current needs and preferences.

The service has processes in place to ensure consumers can access and are referred to appropriate individuals, other organisations and providers in a timely manner.

Most consumers and representatives expressed satisfaction with the choices, quality and quantity of meals. Staff demonstrated understanding of individual consumer’s meal preferences and dietary requirements that was communicated with the kitchen and aligned with care documentation. Staff were observed to be assisting and encouraging consumers with meals during the site audit.

Consumers, representatives and staff were satisfied they had access to suitable and well-maintained equipment. Equipment was observed to be clean, well maintained and readily available.

# 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. | 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

Consumers and representatives provided feedback the service feels like home and they are supported to personalise their rooms. The service was observed to be welcoming and to promote consumer independence and belonging. The service offers a number of comfortably furnished communal spaces that enable consumers to interact with their families and friends. The service was observed to be clean and uncluttered enabling the free movement of consumers. Consumers were observed moving freely throughout the service, accessing internal and external spaces including lounge rooms and gardens.

Consumers and representatives considered the living environment is comfortable and clean. Furniture, fittings and equipment were observed to be clean and well-maintained. Consumers and representative provided positive feedback about the cleanliness of equipment and the responsiveness of maintenance staff. Staff explained maintenance processes and maintenance records demonstrated requests are responded to in a timely manner. Maintenance staff were observed repairing a consumer’s furniture during the site audit.

# 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. | 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:

While staff were able to locate the services open disclosure policies and procedures on the organisation’s online platform, they did not demonstrate understanding of the principles in practice. Two consumers were not satisfied appropriate action was taken in response to their complaints. The service’s continuous improvement plan did not reflect complaints and feedback raised by consumers in consumer meetings.

The Assessment Team found that while management could explain the process to review complaints, the service did not document complaints in a complaints register and actions were not documented in the continuous improvement plan. Consumers and representatives were not aware of any feedback or complaints used to improve quality care and services.

The Assessment Team identified deficits relating to the organisations continuous improvement plan and the documenting of complaints and feedback under Standard 8 Requirement 8(3)(c), I have also considered those deficits under this requirement.

The approved provider responded to the site audit report and accepted the Assessment Team’s findings. The approved provider submitted a detailed action plan demonstrating the actions planned to address the improvements required. Actions include staff training in open disclosure, feedback and complaints to be discussed at consumer meetings, documenting and review of complaints in a register and updating the continuous improvement plan to inform continuous improvement. Complaints will be reviewed to identify trends.

I have reviewed all of the information provided and note the approved provider’s acknowledgement of the information compiled in the site audit report. While I acknowledge the actions taken by the service since the site audit, these actions have not been fully implemented and evaluated. I am not satisfied the service has in place effective systems to ensure feedback and complaints are documented, appropriately actioned, reviewed and used to improve the quality of care and services of consumers. I find requirements 6(3)(c) and 6(3)(d) are non-compliant.

I am satisfied the remaining two requirements of Standard 6 Feedback and Complaints are compliant:

Consumers and representatives can make feedback and complaints through hard copy and electronic complaint forms accessed through the services website. Complaint forms were readily available and feedback boxes accessible throughout the service.

Consumers were aware of the complaint and feedback forms and the external feedback mechanisms available to them when making complaints. Staff described how they assist and support consumers to make feedback and complaints.

# 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. | Non-compliant |

Findings

I have assessed this Quality standard as non-compliant as I am satisfied requirements 7(3)(d) and 7(3)(e) are non-compliant:

Mandatory training data demonstrated that most clinical and care staff had not completed mandatory training, including SIRS and infection control training. Training records demonstrated no registered nurses had completed mandatory training. The service was unable to demonstrate mandatory training is monitored. Management advised the organisation is recruiting a learning and development manager to monitor and follow up the completion of staff training. Staff did not demonstrate understanding of the reportable incident system and the responsibilities related to their role.

The Assessment Team identified deficits in staff understanding and training relating to incident reporting, open disclosure and restrictive practices under Standard 8 Requirements 8(3)(d) and 8(3)(e), I have considered that information and the approved providers response under this requirement.

The Assessment Team found that while the organisation has a performance appraisal process in place it had not been actioned in practice. Management confirmed performance appraisals had not been completed for any staff. Staff confirmed they have not participated in a performance appraisal and that limited feedback is provided to them about their performance.

The approved provider responded to the site audit report and accepted the Assessment Team’s findings. The approved provider submitted an action plan demonstrating the actions planned to address the improvements required. Actions include the commencement of a learning and development manager, scheduled timeline for completion of mandatory training, staff education in incident reporting with follow up monitoring of staff practice and performance reviews to commence later in 2022.

I have reviewed all of the information provided and note the approved provider’s acknowledgement of the information compiled in the site audit report. While I acknowledge the actions taken by the service since the site audit, these actions have not been fully implemented and evaluated. I am not satisfied the service has in place effective systems to ensure the workforce is trained, equipped and supported to deliver outcomes under the Quality standards or that workforce performance is effectively assessed, monitored and reviewed. I find requirements 7(3)(d) and 7(3)(e) are non-compliant.

I am satisfied the remaining three requirements of Standard 7 Human Resources are compliant:

The service is collocated with another service and staff are allocated between the two services on an as needs basis. Mixed feedback was received from consumers and representatives about staffing levels, with concerns raised about the number of staff rostered on overnight. Management advised a registered nurse is rostered at the collocated service overnight who can be accessed for assistance where required. Staff said there were staff shortages and high turnover of staff. The Assessment Team observed staff shortages impacting the timely completion of care documentation including progress notes and charting. While call bell data was unavailable at the time of the site audit, management explained the system is new and there is no data available yet to analysis. Management explained a recruitment process is currently underway to employ more staff. In its response, the approved provider submitted further information including actions taken since the site audit in relation to call bells. In its response the approved provider explained that since taking ownership of the service in March 2022 it has deployed resources to improve IT infrastructure including call bell systems. The approved provider advised no complaints had been received from consumers relating to delayed call bell responses. The service is waiting for the supplier to program the new call bell system so monitoring, review and analysis of trends can commence. While I note the mixed consumer and staff feedback, the information in the site audit report does not demonstrate impact to consumer care and services resulting from staff shortages. I have considered the steps taken by the approved provider to improve the call bell system. On balance, I find, requirement 7(3)(a) is compliant.

Consumers were satisfied staff are kind, caring and respectful and this was supported by Assessment Team observations. Staff demonstrated understanding of the consumers’ needs and preferences and spoke respectfully about consumers.

Overall, consumers were satisfied that staff had good understanding of their care needs. Staff described how they have the necessary qualifications to perform their roles as reflected in their duty statements.

# 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)(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. | 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:

Consumers were not satisfied they are engaged in the development, delivery and evaluation of care and services. Consumers felt their opinions are not valued as they are not consulted about change until after a decision is made. Review of consumer meeting minutes for the period January 2022 to July 2022 demonstrated meetings were either cancelled or only attended by management, specifically the meeting relating to changes planned by the new approved provider. Consumer suggestions were not captured in the service’s continuous improvement plan. The Assessment Team noted that consumer feedback and concerns provided during the site audit were added to the agenda for the upcoming consumer meeting.

The Assessment Team identified deficits in the organisation’s information, continuous improvement. regulatory compliance, feedback and complaints governance systems that demonstrated governance has not been effective at the service level. This is further supported by evidence in the site audit report of deficits relating to staff understanding and application of systems, policies and processes in standard 2, 3, 6 and 7. Staff demonstrated limited understanding and practical application of the new electronic document system and incident reporting, the services continuous improvement plan did not reflect current and accurate information and actions including feedback, complaints and clinical incidents to inform monitoring of trends and areas of improvement.

I have also considered documentation deficits in continuous improvement and feedback and complaints under Standard 6 Requirement 6(3)(d), and deficits in staff training and education under Standard 7 Requirement 7(3)(d).

I am satisfied the services governance is effective in the area of financial governance.

While the service has risk management systems to identify, assess and monitor high impact or high prevalence risks associated with the care of consumers, the systems have not been effective at the service level in managing high-impact or high-prevalence risks, governance systems have not ensured all risks were identified, assessed and risks removed or reduced. The non-compliance identified in this report in Standards 2, 3, and 7 shows staff require more training and education in risk management and incident reporting.

The organisation has a clinical governance framework including policies and procedures for antimicrobial stewardship, minimising the use of restraint, and open disclosure. While staff demonstrated understanding of infection control and how they minimise the use of antibiotics, staff did not demonstrate sufficient understanding of open disclosure and minimising the use of restrictive practices. This is further supported by the non-compliance identified in this report in Standards 2, 3 and 6.

The approved provider responded to the site audit report and accepted the Assessment Team’s findings. Upon taking ownership of the service in March 2022, the approved provider advised it had recognised there existed several areas for improvement. The approved provider submitted a detailed action plan demonstrating the actions planned to address the improvements required. Actions include regular review and monitoring of the services continuous improvement plan to reflect clinical, non-clinical and organisational actions, feedback provided to consumers of outcomes, review of organisational policies and procedures, staff training and education to be delivered on identification and management of high impact and high prevalence risks, incident management reporting, responsive behaviours, restrictive practices, falls management and open disclosure.

I have reviewed all of the information provided and note the approved provider’s acknowledgement of the information compiled in the site audit report. While I acknowledge the actions taken by the service since the site audit, these actions have not been fully implemented and evaluated. I am not satisfied the service has in place effective governance systems, risk management systems and practices, and clinical governance systems and practices to ensure the delivery of safe and quality care and services that meets the Quality standards and consumers are 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.

I am satisfied the remaining one requirement of Standard 8 Organisational governance is compliant:

The governing body promotes a culture of safe, inclusive and quality care and services through the establishment of committees and subcommittees. Documentation reviewed by the Assessment Team confirmed the Board is kept up to date on key performance indicators through monthly reporting. Consumers expressed satisfaction throughout the site audit that they feel safe, respected and are living in an inclusive environment.

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)