Performance

Report

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| Name of service: | St Simeon Village |
| Service address: | 261 Hyatts Road Plumpton NSW 2761 |
| Commission ID: | 0374 |
| Approved provider: | Serbian Orthodox Diocese Aged Care and Education Property Fund |
| Activity type: | Assessment Contact - Site |
| Activity date: | 8 December 2022 to 12 December 2022 |
| Performance report date: | 18 January 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 St Simeon Village (**the service**) has been prepared by G Cherry, 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 5 January 2023
* Performance Report dated 24 April 2022 for site audit conducted 21 to 23 March 2022

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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| Consumer dignity and choice | |  |
| 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 |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of the six specific requirements have been assessed and found compliant.

Requirement 1(3)(c)

A decision was made on 24 April 2022 that the service was non-compliant in requirement 1(3)(c) after a site audit conducted 21 to 23 March 2022. The service was unable to demonstrate that each consumer is supported to exercise choice and independence to make and communicate decisions about their own care and the way they choose delivery of care and services.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted evidence the service has implemented actions in response to previous non-compliance which include processes to clearly identify consumers’ decision making capacity and/or substitute decision makers (and inclusion within consumer documentation), plus provision of staff education in relation to this requirement.

Most consumers and representative’s express satisfaction consumers are supported to exercise choice and independence and maintain relationships that are important to them and gave specific examples of satisfaction. Staff describe how they support consumers to make informed choices about care and services.

Organisational policies detail guidance on supporting consumers to maintain relationships of choice and drive decision-making; staff demonstrate knowledge of the process. The assessment team reviewed documentation which identified substitute decision maker details for those consumers assessed to not have decision-making capacity.

However, the assessment team noted not all consumers have documented details supporting their decision-making ability or who they want involved in decision-making. Some interviewed consumers express dissatisfaction decision-making arrangements are not clear and/or feel their decision-making capacity is not being supported. Documentation details inconsistent information for several of consumers regarding their decision-making arrangements, including nomination of an alternate decision maker when the consumer’s assessment indicates capacity for decision making. A member of the management team noted the consumer is awaiting geriatrician review.

In their response the approved provider evidenced remediation of inconsistent information; medical officer discussion (and consumer agreement) relating to use of medications plus a reduction in psychotropic medication for one consumer. They evidenced that while assessment documentation details decision-making capacity for two consumers, they have also requested representative involvement/support for their decisions. Evidence of geriatrician review was furnished for one consumer, which demonstrates discussion (and consumer ability for decision making) relating to medications. I am satisfied the service demonstrates several methods of consumer discussion/involvement (and agreement) in relation to care and service provision.

I find requirement 1(3)(c) is compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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)(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 Quality Standard was not fully assessed, and therefore has not received a compliance rating. Four of the five specific requirements have been assessed and found compliant.

A decision was made on 24 April 2022 that the service was non-compliant in requirements 2(3)(a),(b),(d) and (e) after a site audit conducted 21 to 23 March 2022.

Requirement 2(3)(a)

The service did not demonstrate effective systems to ensure risks to consumer’s health and well-being are considered, identified and incorporated into care planning documentation, and assessment/planning did not inform effective end of life care, wound and pressure injury management, and/or falls risk.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted evidence the service has implemented actions in response to previous non-compliance. Implemented actions include development of an assessment schedule for new consumers, review files to identify/addressed deficits and provision of staff training. Daily auditing/reporting of consumer clinical care needs, in addition to handover/daily staff discussions enhanced assessment and documentation processes.

Overall, the service demonstrates effective processes for assessing risks and completing care planning documentation. Organisational polices provide high level guidance for clinicians. Interviewed clinical staff demonstrate knowledge of policies and tools available, and monitoring documentation to assist prioritisation/ensure timely completion. Review of documentation details assessment of risk to consumer health and well-being, resulted in care plans demonstrating assessment outcomes and related interventions. Documentation details evidence of discussions with consumers and/or their nominated decision maker and specialist involvement in relation to care planning outcomes. While the assessment team noted differing information within documentation for one consumer it was noted no negative impact resulted.

I am satisfied changes to systems and process, plus documentation review demonstrate effective processes for assessing risks associated with consumer care and related care planning.

I find requirement 2(3)(a) is compliant.

Requirement 2(3)(b)

The service did not demonstrate assessment/planning consistently identifies/addresses consumer’s current needs/goals and preferences when consumers experience a change in condition in relation to wound care, palliative and end of life care, pain assessment/monitoring and mobility.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include daily auditing/reporting on consumer clinical care needs, in addition to handover/daily staff discussions and documented guidance for timeframes resulted in enhanced assessment and documentation processes. Auditing of case conference documentation resulted in monitoring document to guide adherence to timeframes.

Overall, the service demonstrates effective processes for assessing risks and completing care planning documentation. Organisational polices provide high level guidance for clinicians. Interviewed clinical staff demonstrate knowledge of policies/tools available and monitoring documentation to assist prioritisation/ensure timely completion.

Review of documentation details care plans demonstrate assessment outcomes, related interventions to address consumer’s needs/goals and preferences including advanced and end of life care directives. The assessment team observed staff providing care specific to consumers’ needs as per directives. Review of case conference records detail advanced care/end of life wishes are discussed and reviewed with the consumer and/or their nominated decision maker and the service demonstrates currency of communication.

The assessment team noted some consumer files did not contain all information required within behaviour support plans however noted most files detail assessment/care planning directives to guide staff in providing consumer’s individual needs.

In their response the approved provider questioned the assessment team’s assertion re lack of required information. While the assessment team noted a lack of required information in some files, negative consumer impact was not substantiated. I am satisfied changes to systems and processes result in most documentation containing guidance/directives for care provision, plus consumers and representatives’ express satisfaction care needs are met.

I find requirement 2(3)(b) is compliant.

Requirement 2(3)(d)

The service did not demonstrate methods of effectively communicating outcomes of assessment/planning.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include daily auditing/reporting on consumer clinical care needs, in addition to handover/daily staff discussions, and documented guidance for timeframes resulted in enhanced assessment and documentation processes. Auditing of case conference documentation resulted in monitoring document to guide adherence to timeframes and a newly implemented process to provide a copy of the care plan to consumers and/or representatives post care plan review.

The service demonstrates effective processes to ensure outcomes of assessment/planning are communication to consumers/representatives, including provision of a copy of care plan. Organisational policies include guidance about communicating outcomes of assessment and care plan availability to consumers and/or representatives. Interviewed consumers and representatives’ express satisfaction of being informed of assessment outcomes and offered a copy of documentation.

Clinical staff demonstrate knowledge of systems/processes to support this and staff demonstrate awareness of consumers’ care needs/preferences and goals. They evidenced documentation availability at point of care, dietary information in relevant serveries/kitchens, plus knowledge of accessing electronic documentation. Interviewed consumers and representative’s express satisfaction of assessment/care planning outcomes, being updated when changes occur and accessibility of documentation.

I am satisfied changes to systems and process result in outcomes of assessment/planning effectively communicated to consumers/representatives including provision of documentation.

I find requirement 2(3)(d) is compliant.

Requirement 2(3)(e)

The service did not demonstrate care and services are consistently and regularly reviewed for effectiveness, when circumstances change and/or incidents impact consumers’ needs, goals or preferences.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include daily auditing/reporting on consumer clinical care needs, in addition to handover/daily staff discussions and documented guidance for timeframes resulted in enhanced assessment and documentation processes. A care plan review schedule has been implemented to ensure currency of care plans and intervention effectiveness is documented. Staff training occurred to impress importance and understanding of care plan currency when consumer’s needs change.

Organisational policies include guidance for clinicians to assess consumers regularly as per timeline schedule and when needs change, or incidents occur. Interviewed clinical staff demonstrate knowledge of processes and tools. The service’s monitoring system details currency of assessment/care plans. Documentation reviewed by the assessment team evidenced regular review of care and services reflected consumers current needs/goals and preferences. For example: reassessment, medical officer review of pain medications, monitoring and evaluation of effectiveness, physiotherapy review, changes to manual handling directives and regular wound care review for a consumer recently returned from hospital. A new exercise program for strength and balance was implemented for another consumer post fall, and review of falls risk assessments demonstrate falls prevention/mitigation effectiveness.

I am satisfied changes to systems and process result in services being regularly reviewed for effectiveness when consumers’ circumstances change (including incidents).

I find requirement 2(3)(e) is 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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 |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Five of the seven specific requirements have been assessed and found compliant.

A decision was made on 24 April 2022 that the service was non-compliant in requirements 3(3)(a),(b),(c),(d) and (e) after a site audit conducted 21 to 23 March 2022.

Requirement 3(3)(a)

The service did not demonstrate each consumer gets relevant care which is best practice and tailored to their needs in relation to skin/wound care, restrictive practices, clinical monitoring process and incident management.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include development of post hospitalisation checklist to ensure appropriate care provision. Wound specialist from local hospital visiting monthly (and when required) plus commencement of a nurse practitioner. Pain management policy and procedures were reviewed/updated. Each consumer has been re-assessed for pain, assessment/care plans in place, and the physiotherapist is providing massage and non-therapeutic interventions. An electronic medication management system has been implemented. Review of restrictive practice documentation to include Behaviour Support Plans and psychotropic medication. Provision of education to clinical staff relating to restrictive practices, assessment/care planning, skin integrity/wound care and pain management.

Overall, the service demonstrates effective systems to ensure each consumer gets safe and effective personal/clinical care. All interviewed consumers and/or representatives’ express satisfaction with care and services, giving examples of specific personal/clinical care received. Interviewed staff demonstrate knowledge of assessment and care planning process resulting in positive consumer outcomes.

Documentation review noted most consumers receive safe and effective personal and clinical care, which is best practice, tailored to needs and optimises health and well-being. Positive examples include skin integrity/pressure injury/wound management, pain management and identification/management of restrictive practices. The organisation’s restrictive practice policy reflects regulatory obligations and best practice. Management staff evidenced a reduction in restrictive practices. Documentation review details a recording and monitoring process for psychotropic medications and care documentation demonstrates appropriate psychotropic medication use for individual consumers. Regular review occurs in relation to the ongoing need of this medication. The assessment team noted a deficit in the identification/management of medication deemed as a restrictive practice for one consumer which as addressed when bought forward to management team. On balance, the service demonstrates close monitoring with comprehensive assessment/care planning documentation to guide care provision in relation to each consumer.

Policies and procedures reflect best practice guidelines regarding pain management. Documentation review and interviews with consumers/representatives demonstrate the service has effective methods for ensuring consumer pain management needs are met. Pain assessments are conducted and medication, plus non-pharmalogical alternatives utilised in pain treatment. Monitoring process ensure effectiveness and pain-relieving medications are administered prior to undertaking exercises/activities.

Policies and procedures reflect best practice guidelines regarding management of skin integrity, pressure injuries and wound management. Documentation review demonstrates positive outcomes relating to pressure injury/wound management. Wound specialists are engaged to review wounds and directives followed resulting in healing of wounds.

I am satisfied changes to systems and process result in effective systems to ensure each consumer gets safe and effective personal and clinical care.

I find requirement 3(3)(a) is compliant.

Requirement 3(3)(b)

The service did not demonstrate effective management of high impact or high prevalence risks associated with each consumers’ care.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include review of high impact risk register to include classification/specialists/allied health referrals. Review and updating of a clinical risk register and implementation of policy/procedures. Review/investigation of consumer falls/trending/analysis conducted, and policy/procedures reviewed to ensure guidance of neurological observations when required. Monitoring of weight changes, dietitian review and weight loss preventative strategies have been implemented. Provision of education to clinical staff relating to incident and falls management.

The service demonstrates effective management of high impact or high prevalence risks associated with the care of each consumer. Policies guide staff in the management of complex health care needs such as catheter, stoma, diabetes and reflect best practice guidelines. Incident/falls and weight management policies guide clinicians to regularly assess consumers and gain specialist review. All interviewed consumers and representative’s express satisfaction regarding incident management/ensuring consumer safety and complex care needs being met. Representatives gave examples of improved consumer outcomes. Interviewed staff demonstrate knowledge of monitoring processes and care provision regarding individual consumer’s complex health needs, weight loss, incident and falls management.

Documentation review demonstrate reporting, investigation and implementation of effective preventative strategies regarding incident management; specialist directives and monitoring documentation to ensure appropriate care delivery. Consumers express satisfaction with physiotherapy review, preventative strategies and rehabilitation program post fall, plus specialist review when incidents and/or unplanned weight loss occurs. The assessment team observed staff assisting consumers with care as per specialist directives, demonstrating knowledge of each consumer’s individual risk.

I am satisfied changes to systems and process result in effective management of high impact/high prevalence risks associated with each consumer’s care.

I find requirement 3(3)(b) is compliant.

Requirement 3(3)(c)

The service did not demonstrate needs, goals, and preferences of consumers nearing the end of life are recognised and addressed to ensure their comfort is maximised. Assessment/planning did not consistently guide care delivery to address needs regarding palliative/end of life care.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include review of policy/procedure documentation to guide staff in palliative care provision and staff received training/education; file review ensured advance care planning directives align with consumer’s wishes.

The service demonstrates effective processes to ensure needs, goals and preferences of consumers nearing the end of life are recognised/addressed, their comfort maximised, and dignity preserved. Policies guide staff in the provision of palliative and end of life care management. All interviewed consumers and representative’s express satisfaction discussions have occurred relating to advance care directives/end of life wishes, medical officer and/or palliative care team review regularly occurs, medication and/or other directives are adhered to in providing appropriate care. Two representatives gave positive feedback about end of life care of a loved one. Interviewed staff demonstrate knowledge of methods to ensure consumers’ comfort and dignity is maximised; for example, provision of regular oral care, repositioning, administration of pain medication, aromatherapy and/or care as per consumer’s individual wishes. Documentation review demonstrate sampled consumers have an advanced care directive with consumer/representative input during regular case conference meetings. Directives reflect consumer’s needs, goals and preferences.

I am satisfied changes to systems and process result in effective management to ensure needs, goals and preferences of consumers nearing end of life are recognised/addressed, their comfort maximised, and dignity preserved.

I find requirement 3(3)(c) is compliant.

Requirement 3(3)(d)

The service did not demonstrate deterioration in consumers’ condition is recognised and responded to in a timely manner. Limited monitoring occurred and the service did not demonstrate development/implementation of effective interventions/strategies to prevent ongoing deterioration.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include review of relevant policy/procedures and provision of staff education. A review of documentation to identify those consumers who experienced a deterioration/change in condition resulted in reassessment/development of updated care plans in consultation with consumers and/or representatives.

The service demonstrates effective processes to ensure deterioration/change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. Policies guide staff in best practice guidelines regarding recognising and responding to deterioration or changes in health. All interviewed consumers and representative’s express satisfaction with management of care when consumers become unwell and/or experience a change in health condition. Interviewed care staff demonstrate knowledge of methods to report changes to clinical staff, acknowledging reassessment in a timely manner. Clinical staff direct care provision and demonstrate knowledge of review processes including subsequent monitoring and neurovascular observations, conducting head-to-toe assessment, delirium screen and/or referral to medical officer/specialist, hospital transfer if required. Documentation review demonstrate sampled consumers receive timely identification and response to ensure appropriate clinical care.

I am satisfied changes to systems and process result in effective management of deterioration/change in a consumer’s mental health, cognitive or physical function is recognised and responded to in a timely manner.

I find requirement 3(3)(d) is compliant.

Requirement 3(3)(e)

The service did not demonstrate information about consumers’ condition, needs and preferences is accurately documented and/or effectively communicated with those providing/supporting care delivery.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include transfer of all relevant data onto the new electronic care planning system to ensure consistency, easy access to information and support monitoring of care/service requirements.

The assessment team noted most information relating to consumers’ condition, needs/preferences is documented and effectively communicated to all where responsibility for care is shared. Interviewed clinical staff demonstrate knowledge of methods use for information transfer, noting receipt of appropriate information via summary care plans and handover discussions. Documentation review for sampled consumers demonstrates alignment of information between care plans and handover documentation. Consumers and representative’s express satisfaction of notification when changes/incidents occur and receipt of documented care plans. Interviewed staff demonstrate knowledge of methods utilised to transfer consumers current care needs including individual care plans, daily handover discussions/report review and summary care plan documentation availability. Via documentation review the assessment team noted variations in documented dietary requirements for one consumer, which management committed to updating, however the team noted variations in documentation did not result in negative impact.

I am satisfied changes to systems and process generally result in accurate documentation and effective transfer/communication of consumer’s needs.

I find requirement 3(3)(e) is compliant.

# 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 |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Two of the seven specific requirements have been assessed and found compliant.

A decision was made on 24 April 2022 that the service was non-compliant in requirements 4(3)(a) and (b) after a site audit conducted 21 to 23 March 2022.

Requirement 4(3)(a)

The service did not demonstrate each consumer receives 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/quality of life in relation to being engaged in activities of choice and in a language in which they communicate.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include adjustments to lifestyle programs to promote meaningful engagement with consumers leading to daily activities planned with consumer input. Review of lifestyle assessments/care plans in consultation with consumers/representatives to ensure notations reflect consumers current needs/preferences.

The service demonstrates safe and effective care, services and supports for daily living meet consumer’s needs/goals and preferences and optimises independence, health, well-being and quality of life. Interviewed consumers and representatives express positive feedback relating to services and supports as per consumer’s needs/preference. Consumers gave examples of activities they choose, and support received from staff and volunteers to enable them to participate.

Document review demonstrate alliance between consumers assessed needs and requests and participation records. Interviewed staff demonstrate knowledge of consumers individual likes/preferences, consumers involvement in development of programs and how they support consumer participation (including provision of information in multiple languages).

I am satisfied changes to systems and process result in each consumer receiving safe/effective services that meet their needs, goals, preferences and optimises independence, health and quality of life.

I find requirement 4(3)(a) is compliant.

Requirement 4(3)(b)

The service did not demonstrate supports for daily living promote each consumer’s emotional, spiritual and psychological well-being, including at end of life.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include adjustments to lifestyle programs to promote meaningful engagement with consumers leading to daily activities planned with consumer input. Review of lifestyle assessments/care plans in consultation with consumers and representatives to ensure care plans reflect consumers current needs/preferences.

The service demonstrates provision of a range of leisure and lifestyle activities support consumers to do the things they like, including engagement of consumers and representatives in decision making to optimise their quality of life. Interviewed consumers and representative’s express satisfaction relating to emotional and spiritual support received. Documentation review demonstrates evidence of emotional and spiritual support provision. Management staff demonstrative response actions to feedback relating to a consumer requesting spiritual support and the assessment team observed staff providing consumers with support. Staff demonstrate awareness of benefits in engaging consumers in meaningful activities and informed of processes and external organisations/support services used in doing so. Positive outcomes to consumers’ emotional and psychological well-being were noted.

I am satisfied changes to systems and process result in consumers receiving services and supports for daily living which promote emotional, spiritual and psychological well-being.

I find requirement 4(3)(b) is 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Two of the four specific requirements have been assessed and found compliant.

A decision was made on 24 April 2022 that the service was non-compliant in requirements 6(3)(c) and (d) after a site audit conducted 21 to 23 March 2022.

Requirement 6(3)(c)

The service did not demonstrate open disclosure practices are consistently utilised when appropriate and/or complaint management consistently lead to sustained improvement.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Improvements include conducting a meeting to inform consumers and representatives of the findings of the Site Audit visit in March 2022 advising of actions and progression of required improvements, with commitment to provide regular, ongoing updates.

Interviewed consumers and representative’s express satisfaction members of the management team are approachable, which assists them to feel comfortable in raising concerns/complaints, although not all had experienced a reason to do so. Consumers/representatives have awareness of others raising concerns, citing satisfaction with responsiveness/outcome.

Interviewed staff demonstrate understanding of their role/responsibilities relating to complaints management; for example, assisting those who provide feedback and/or escalating concerns to clinical staff and/or in consultation with members of the management team. Interviewed management team members demonstrate awareness of principles relating to open disclosure and actions implemented to minimise reoccurrence of incidents and/or complaint issues.

Documentation review reflects investigation of feedback and complaints, communication and open discussions with complainants and examples of immediate/responsive actions to ensure positive outcomes and satisfaction. Where required, updates/outcomes are discussed at group meetings and regular status provided.

I am satisfied changes to systems and process result in the service demonstrating an effective system of complaints management and open disclosure practices implemented when required.

I find requirement 6(3)(c) is compliant.

Requirement 6(3)(d)

The service did not demonstrate effective trending or analysis of complaints/feedback, or that feedback consistently drives continuous improvement/changes to the quality of care and services.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Improvements include review of complaints to ensure appropriate documentation and response within a timely manner and provision of staff training/education. This resulted in management staff gaining a better understanding of and ability to monitor/review complaint outcomes.

Interviewed consumers and representative’s express satisfaction members of the management team respond to feedback which is used to make improvements and positive outcomes; examples of improvement for individual consumers and/or overall service improvement were noted. Interviewed staff demonstrate understanding of their role/responsibilities relating to complaints management and mechanism for improvement outcomes. Documentation review reflects consumer satisfaction with improvement outcomes.

I am satisfied changes to systems and process result in the service demonstrating an effective system of utilising feedback and complaint to improve quality of care and services.

I find requirement 6(3)(d) is compliant.

# 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)(c) | The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Two of the five specific requirements have been assessed and found compliant.

A decision was made on 24 April 2022 that the service was non-compliant in requirements 7(3)(a) and (c) after a site audit conducted 21 to 23 March 2022.

Requirement 7(3)(a)

The service did not demonstrate an effective system to ensure deployment of the workforce to enable delivery and management of safe and quality care and services.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include employment of additional staff and implementation of a new rostering system noting staffing numbers and skill mix in response to current consumer cohort needs. Improvement to call bell response times as a result of implementing a new system.

Most interviewed consumers and representatives consider enough staff numbers. Interviewed staff noted most duties are completed within allocated shifts; advising of methods implemented when unplanned leave is not able to be replaced. A member of the management team detailed actions implemented to ensure stability of workforce and culture change/improvement including employment of additional staff and mechanisms to monitor/respond to unplanned leave, plus supporting staff to undertake education/training to increase skill level. Documentation review noted improved timeframes of staff responding to consumers’ requests for assistance.

I am satisfied changes to systems and process result in an adequate workforce to enable delivery/management of safe and effective care and services.

I find requirement 7(3)(a) is compliant.

Requirement 7(3)(c)

The service did not demonstrate a competent workforce or members of the workforce have qualifications and knowledge to effectively perform their roles; particularly relating to Standards 2 and 3, or an appropriately trained infection prevention and control (IPC) lead.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance. Implemented actions include review to ensure staff have the appropriate/relevant qualifications for their role requirements; including an additional clinical staff member undertaking education/training required for Infection Prevention Control Lead (IPC).

Interviewed consumers and representatives consider staff have knowledge and skills to meet consumers’ needs/preferences. Documentation review demonstrate provision of extensive training covering all areas of the Quality Standards, including regulatory changes. Clinical staff gave examples of methods utilised to ensure training/education effectiveness and monitor staff knowledge; including provision of additional training when gaps in knowledge are identified.

All interviewed staff acknowledge access to information/training including manager/supervision processes to monitoring skills/knowledge and address areas of concern. Staff demonstrate awareness of topics relating to the Quality Standards, including examples of implementing responsibilities of their role; such as response to identification of elder abuse and or practices to minimise transfer of infection. Clinical staff referenced receipt of extensive information/training relating to appropriate personal and clinical care and demonstrate knowledge of policies including principles of best practice and legislative regulations.

Management team members noted actions implemented to ensure appropriate staff qualifications, including visiting medical officers, allied health professionals, pharmacists and specialists; staff undertaking third party training courses and multiple staff having obtained relevant IPC lead qualifications to enable consistent coverage.

I am satisfied changes to systems and process result in demonstration of a competent workforce with the knowledge and qualifications to effectively perform roles and ensure consumers’ needs are met.

I find requirement 7(3)(c) is compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(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:   * antimicrobial stewardship; * minimising the use of restraint; * open disclosure. | Compliant |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Four of the five specific requirements have been assessed and found compliant.

A decision was made on 24 April 2022 that the service was non-compliant in requirements 8(3)(a),(c),(d) and (e) after a site audit conducted 21 to 23 March 2022.

Requirement 8(3)(a)

The service did not demonstrate consumers are supported and/or engaged in the overall development, delivery and evaluation of care and services.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance.

Implemented actions include:

* Improving structures to support consumers in partnering in care and service delivery and improving information delivery to the governing body.
* Providing opportunities for consumers and representatives to be involved in service operation by involving consumers in leadership/governance meetings.
* Communication to all representatives regarding meeting forums to enable attendance.
* Direct engagement with consumers and families resulting in additional recreational staff and amendments to lifestyle services increasing consumer social engagement.

Consumers and representatives consider they are supported to engage in development and delivery of care and services and partner in improvements. Examples include being involved in meeting forums, improvements to meal service and changes to medications.

Members of the governing body regularly attend the service, engage with consumers/representatives and review relevant meeting minutes to oversee consumer feedback/input. Policies guide staff in organisational expectations regarding consumer/representative involvement. Documentation review noted consumer engagement in leadership/governance meetings and feedback/input sought in relation operational aspects resulting in recent improvement activities.

I am satisfied changes to systems and process result in the service demonstrating an effective process for consumer engagement in development and delivery of care and services.

I find requirement 8(3)(a) is compliant.

Requirement 8(3)(c)

The service did not demonstrate consistently effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance.

Implemented actions include

* Improving structures to support effective governance framework
* Implement a new electronic care planning system to ensure documentation is within a single, accessible system.
* Implement a quality framework including auditing/monitoring schedules and all actions within the plan for continuous improvement document; trending and analysis to be conducted.
* Implement a regulatory compliance register to record/monitor required information.

Consumers and representatives consider the service to be well run and express satisfaction with managing systems and processes. Members of the governing body regularly attend the service, engage with consumers/representatives, review relevant meeting minutes/forums and engage with management team members in relating to staffing and operational aspects and topics relating to the Quality Standards. Effective governing body oversight was demonstrated. Policies guide staff in organisational expectations. While the assessment team noted some conflicting information in relation to monitoring and decision-making processes and one consumer’s psychotropic medication not included in restrictive practice documentation. They noted behaviour support plan not aligning with current directives for one consumer, however acknowledged information available in alternate formats.

I have considered lack of information within required formats for one consumer and accept availability of information and staff awareness of consumer’s needs. I am satisfied changes to systems and process result in effective governance systems.

I find requirement 8(3)(c) is compliant.

Requirement 8(3)(d)

The service did not demonstrate effective risk management systems including management of high impact/high prevalence risks associated with consumers’ care, and/or an effective incident management system.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance.

Implemented actions include

* Improving structures to support effective governance framework
* Implement a new electronic care planning and incident management system
* Review of policies/procedures, implementation of monitoring and auditing systems
* Provide staff education/training in relation to new systems.

The service demonstrates effective organisational and documented risk management systems and processes. Documentation reflects governing body responsibility for risk management; board members’ determination of appropriate risk appetite and a risk management framework which details strategic/high level operational risk and processes for regular review. Governing body expectations relating to risk oversight are known and managed by management team members. High impact/high prevalence risks are monitored and strategies for management are regularly discussed.

Policies guide staff in organisational expectations. Staff demonstrate awareness of incident reporting and documentation details appropriate reporting, implementation of immediate and preventative strategies, plus reporting to regulatory bodies when required. Staff demonstrate awareness of importance relating to consumer’s quality of life and gave examples of consumer support provided to achieve outcomes.

Interviewed consumers and representatives consider consumers receive appropriate support to live the best life and as per choice: examples include consumers being supported to do things of importance relative to their individual needs/preferences.

I am satisfied changes to systems and process result in effective risk management systems.

I find requirement 8(3)(d) is compliant.

Requirement 8(3)(e)

The service did not demonstrate an effective clinical governance framework to ensure safe and effective clinical care, nor that open disclosure principles are consistently practiced in response to complaints and/or incident management.

At an Assessment Contact conducted 8-12 December 2022 the assessment team noted the service has implemented actions in response to previous non-compliance.

Implemented actions include

* Improving structures to support an effective clinical governance framework
* Provision of staff education/training relating to minimising use of restrictive practices and principles of open disclosure
* Improvement in the management of restrictive practices and promotion of a restraint free environment. Positive outcomes include a reduction in consumers requiring restrictive practices.

Effective processes ensure governing body oversight and direction of a clinical governance framework in support of safe/quality consumer care/services. Policies guide staff in organisational expectations. Interviewed staff demonstrate knowledge of their role in minimising and managing restrictive practices, principles of open disclosure, antimicrobial stewardship and minimising transmission of infections. Monitoring and auditing processes review currency and compliance. Documentation details review/re-assessment of consumers needs resulted in a reduction in restrictive practices. The service demonstrates a culture of open disclosure including updating consumers on the service’s status relation to regulatory requirements/compliance.

I am satisfied changes to systems and process result in an effective clinical governance framework relating to antimicrobial stewardship, minimising restrictive practices and principles of open disclosure.

I find requirement 8(3)(e) is compliant.

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