Performance

Report

**1800 951 822**

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| Name: | Sunnyside House |
| Commission ID: | 3015 |
| Address: | 1 Adeney Street, CAMPERDOWN, Victoria, 3260 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 3 October 2024 |
| Performance report date: | 31 October 2024 |
| Service included in this assessment: | Provider: 803 Sunnyside House Inc  Service: 1774 Sunnyside House |

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 Sunnyside House (**the service**) has been prepared by M Murray, 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 (performance assessment) – non-site report was informed by review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 22 October 2024
* the performance report for the assessment contact of 3 July 2024.

# Assessment summary

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| Standard 8 Organisational governance | Not 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.

* Embed structures and processes to support effective monitoring of care delivery and consumers’ clinical outcomes.

# Standard 8

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| Organisational governance | |  |
| 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. | Not Compliant |

Findings

The service was found non-compliant with Requirement 8(3)(e) at a Site Audit on 5 September 2023 to 7 September 2023 and at a further Assessment Contact conducted on 3 July 2024. It was determined at the Assessment Contact that the service did not effectively demonstrate a system or process of clinical governance, reflective of the relationships and/or responsibilities between the organisation’s governing body, executive, clinicians, and consumers to achieve effective clinical outcomes overall. It was identified that the service was not identifying when environmental restraints were in use and as such processes for the oversight and the minimisation of restraint were found to be ineffective.

The Assessment Team’s report provides evidence of scheduled actions planned to address deficiencies identified, including, but not limited to the implementation of a clinical governance subcommittee, implementation of a restraint register and staff education.

The Assessment Team noted some of these improvements had not been fully implemented and their effectiveness had not been evaluated. In relation to Requirement 8(3)(e) the Assessment Team recommends a continuing ‘Not Met.’

At this assessment of performance, the Assessment Team were advised a new chief executive officer has recently been appointed.

The Assessment Team’s report shows the service has introduced a clinical governance subcommittee as planned, which management advised will meet every 3 months. An initial meeting of the subcommittee was conducted on 12 September 2024, and it presented a report to the Board at its meeting on 26 September 2024. The Assessment Team report notes minutes of this Board meeting were not available at the time of the Assessment Contact. The Assessment Team found that while the subcommittee has been established, the service did not demonstrate consideration of how it will evaluate, monitor, and review the effectiveness of this subcommittee.

The incoming chief executive officer at the service outlined to the Assessment Team a preliminary analysis which identified gaps in the restrictive practice register. Plans are in place to strengthen the service’s ‘resident of the day’ program to underpin elements of the service’s clinical governance framework.

At the time of the Assessment Contact the service provided records demonstrating that most staff completed training in relation to minimising restrictive practices in 2023 and early 2024.

The approved provider’s response to the Assessment Team’s report does not dispute the recommendation of the Assessment Team.

The response includes a gap analysis / continuous improvement plan which notes:

* a review of communication pathways regarding clinical matters
* actions strengthening the delivery of clinical quality and safety performance data to the Board, not limited to resident feedback, compliments, audit results and fluctuations in safety related clinical outcomes
* Board meetings will include an agenda item on organisational strategy considerations in line with data and information from the service’s quality management system
* actions to strengthen links between the clinical governance committee and the quality care advisory body
* further training of staff on their roles and responsibilities to provide safe quality care in line with the clinical governance framework.

The response does point to an inaccuracy in the Assessment Team’s report, and I accept the approved provider’s evidence that Board meeting minutes were not requested by the Assessment Team.

I also acknowledge the approved provider’s commitment to continuous improvement as outlined in their response and confirmation that relevant actions are currently being addressed.

Based on the information summarised above, I am satisfied that the approved provider does not comply with Requirement 8(3)(e) in Standard 8 Organisational governance. A number of continuous improvement actions to support a return to compliance in Requirement 8(3)(e) are incomplete or an evaluation of the effectiveness of these actions has not yet occurred.

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)